St. Michael's Hospital : Family Medicine Obstetrics Referral Form

Pls fax into SMH at Fax: 416-864-6051

Date: _____

Patient:

Name: _____
D.O.B: _____
Address: _____
Preferred contact phone number: _____

Referral Source:

☐ patient (pls move on to next section)

Name: _____
Address: _____
Preferred contact phone number: _____
OHIP billing number (if applicable) _____

Pregnancy information:

Due Date (EDD): _____

☐ by first trimester US
☐ By LMP

Comments (optional):

_____
_____
_____

☐ Would like FMOB SMH to follow patient immediately for antenatal care
☐ Would like FMOB SMH to start following patient after 20 wk Gestation/anatomical US
☐ Would like FMOB to follow the newborn until weight gain has been established and jaundice has resolved

Checklist (if available):

Antenatals (MOH antenatals 1,2, 3) attached ☐

Imaging to date attached ☐

Labwork to date attached ☐