



Department of Obstetrics and Gynecology

Obstetrics Referral Request

Fax: (416) 530- 6824

Web Page: www.stjoe.on.ca/fbc

Please Complete All Patient Information:

Name: _____ DOB: _____ OHIP #: _____

Day phone: _____ Established EDC: _____ Gravida: _____ Para: _____

Address and postal code: _____

How Soon You Want Your Patient Seen:

Routine Within 1 week Within 2 weeks

Preferred Service:

Obstetrician High Risk Family doctor Midwife

Addictions (The Toronto Centre for Substance Use in Pregnancy T-CUP)

No preference Preferred Care Provider Name: _____

Clinical/Social Concerns: _____

Please Forward Documentation that Applies:

Antenatal I and II 1st & 2nd Trimester US IPS/FTS Antenatal Blood Work

Others e.g. Lab., BPP, consult or surgical notes: _____

Referring Healthcare Provider Information:

Name: _____ Phone: _____ Fax: _____

Billing #: _____ Signature _____ Do you prefer shared care? Yes No

To be Completed by St. Joseph's Health Centre Staff:

Appointment date: _____ Time: _____

Care Giver name: _____ Phone: _____ Fax: _____

Address: _____