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

PLEASE FAX TO: 416-867-7498
Phone: 416-360-4000 Ext 48509

Date: ______________________________

Patient:

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

Referral Source: ☐

***PATIENT CAN SELF REFER** (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):

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☐ 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 ☐