# HIGH RISK PREGNANCY REFERRAL

UNITY HEALTH TORONTO

Date_____

To: **MATERNAL FETAL MEDICINE DIVISION**
- **Dr. Berger ▪ Dr. Chandrasekaran**
- **Dr. Freire-Lizama ▪ Dr. Harris ▪ Dr. Lausman**

**61 Queen St E, 4th Floor**
**Toronto ON M5C 2T2**

**Fax: 416 864-6073**
**Phone: 416 867-7421** ***(Clinic)***
**416 864-6060 ext 2395**
***(Admin office)***

## I would like to refer my patient to the Maternal Fetal Medicine clinic for:

☐ One-time consultation ☐ Shared care ☐ Transfer of care

**Patient Contact Information:** Name
Address
OHIP number
Phone number(s)

***This referral is for a consultation and Obstetric ultrasound. This referral covers follow up clinic visits and repeat ultrasounds that might be needed***

**Clinical Information**: Gravity/Parity _____EDD_____

**Reason for Referral:**

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***Note: All antenatals, ultrasounds and relevant lab results should be forwarded with the referral***

Referred by: _____

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Billing #: _____