

HIGH RISK PREGNANCY REFERRAL

Date _____

To: **MATERNAL FETAL MEDICINE DIVISION**

- Dr. Ausman ▪ Dr. Berezowsky ▪ Dr. Lausman
- Dr. Chandrasekaran ▪ Dr. Freire-Lizama

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:

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

Referred by: _____

Billing #: _____