



Patient ID

**PRENATAL CLINIC
REFERRAL FORM**

T: 416-867-7421

F: 416-867-3742

obreferral@smh.ca

Women's Health Care
61 Queen Street East, 4th floor
Toronto, ON M5C 2T2

Referral Date:

Patient Demographics:

Last Name: _____ First Name: _____ Preferred Name: _____

Birth Date: _____ Gender: _____ SMH MRN (J#): _____

Primary Phone No.: () _____ Alternate Phone No.: () _____

OHIP No.: _____ Email: _____

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> 1st Available | <input type="checkbox"/> Dr. S. Gold | <input type="checkbox"/> Dr. N. Chandrasekaran | <input type="checkbox"/> Dr. T. Freire-Lizama | <input type="checkbox"/> Dr. S. Kives |
| <input type="checkbox"/> Dr. A. Lausman | <input type="checkbox"/> Dr. Y. Liu | <input type="checkbox"/> Dr. F. Meffe | <input type="checkbox"/> Dr. A. Simpson | <input type="checkbox"/> Dr. S. Mathur |
| <input type="checkbox"/> Dr. R. Shah | <input type="checkbox"/> Dr. E. Shore | <input type="checkbox"/> Dr. M. Yudin | <input type="checkbox"/> Dr. D. Soroka | <input type="checkbox"/> Dr. A. Nensi |
| <input type="checkbox"/> Dr. E. Mocarski | <input type="checkbox"/> Dr. C. McCaffrey | <input type="checkbox"/> Dr. S. Im (Fax: 416-977-5572) | <input type="checkbox"/> Dr. A. Berezowsky | <input type="checkbox"/> Prenatal Substance Use Walk-in Clinic |
| | | | | <input type="checkbox"/> Dr. J. Ausman |

PLEASE INCLUDE ANY ULTRASOUNDS AND RELEVANT LAB RESULTS WITH THE REFERRAL

Clinical Information	Gravity/Parity _____	Relevant History
	LMP _____	
	EDD _____	
	Antenatal bloodwork performed YES <input type="checkbox"/> (Please attach) NO <input type="checkbox"/>	

NIPT PERFORMED? YES (PLEASE ATTACH RESULT) NO

EFTS PERFORMED? YES (PLEASE ATTACH RESULT) NO (Will arrange visit at 11-13w with NT scan)

REFERRING PHYSICIAN

Referring Physician/Address (print): _____	Telephone: _____	Billing#: _____
Signature _____	Fax: _____	

TO BE COMPLETED BY WOMEN'S HEALTH CENTRE STAFF

Appointment Booked with Dr:	Date:	Time:

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