


**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:

Birth Date:

SMH MRN (J#):

Primary Phone No.: ()

Alternate Phone No.: ()

OHIP No.:

- ☐ **1st Available**
 ☐ Dr. H. Berger
 ☐ Dr. N. Chandrasekaran
 ☐ Dr. T. Freire-Lizama
 ☐ Dr. S. Kives
☐ Dr. A. Lausman
☐ Dr. D. Robertson
☐ Dr. F. Meffe
☐ Dr. D. Soroka
☐ Dr. A. Simpson
☐ Dr. K. Harris
☐ Dr. R. Shah
☐ Dr. E. Shore
☐ Dr. M. Yudin
☐ Dr. A. Nensi
☐ Prenatal Substance Use Walk-In Clinic
☐ Dr. E. Mocarski
☐ Dr. C. McCaffrey
☐ Dr. S. Im **(Fax: 416-977-5572)**

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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