NORTH YORK GENERAL

Making a World of Difference

MATERNAL FETAL IMAGING
Referral Form

Form SF0005 Rev. 08/2017

Referral Date: _____

PATIENT NAME: _____

Date of Birth (yy/mm/dd): _____ Address: _____

Health Card #: _____ City: _____ Postal Code: _____

Home #: _____ Alternate #: _____

Interpreter Needed? ☐No ☐Yes Language: _____

Referring Physician / Midwife: _____ Phone: _____

Address: _____ Fax: _____

E-mail: _____ OHIP Billing #: _____

REASON FOR REFERRAL: ☐ Consult ☐ Repeat Imaging

Maternal Age: _____yrs LMP: _____ EDC: _____ Gestational Age: ___ weeks

☐ Maternal Concerns:

☐ Fetal Concerns:

The following documentation is required to process this referral:

- ☐ Antenatal Records
- ☐ All relevant antenatal blood work
- ☐ FTS / IPS / MSS Results
- ☐ Ultrasound Results
- ☐ Reports from other specialist involved in the Patient's Care
- ☐ Other lab tests pertinent for referral
- ☐ Reports of abnormal findings in previous pregnancy of child (i.e. ultrasounds, autopsy, chromosomes)

Please Fax referral and any relevant documentation to:

NYGH Medical Imaging Department
Phone: 416-756-6176 Fax: 416-756-6370

MFM Physicians: (select appropriate physician)

- ☐ **Dr. Shilletto**
- ☐ **Dr. Mei Dan**

Radiologists: Dr. O'Hayon, Dr. Causer, Dr. Armstrong, Dr. Tunis, Dr. Lamere, Dr. MacAdam