NORTH YORK GENERAL

Making a World of Difference

MATERNAL FETAL MEDICINE CLINIC
Referral Form

Form SF0005 Rev. 06/2024

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 ☐ Transfer of Care

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

☐ Non-Pregnant Consultation

☐ 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:
Maternal Fetal Medicine Clinic 2nd floor, 4001 Leslie Street Toronto ON, M2K 1E1
Tel: (416) 756-6444 Ext: 4052 Fax: (416) 756-6355