

## **Special Pregnancy Program**

## **Ontario Fetal Centre / Medical Disorders in Pregnancy**

Frances Bloomberg Centre for Women's and Infants' Health 3rd Floor, 700 University Avenue, Toronto, Ontario M5G 1Z5

## Tel: 416-586-4800 x 7756 Complete all of the following information and FAX to: 416-586-3216

Referred to (Physician's Name):				
Referring Physician / Midwife Information				
Name:		Phone:	(	)
Address:		Fax:	(	)
Email address:	OHIP Billing No.			
Patient In	formation			
Name:		Phone:	(	)
Date of Birth:	ealth Card Number:			
Does patient need a translator? No Yes If yes, sp	ecify language:			
Previous referral to another specialty in <i>this</i> pregnancy?				
Reason for Referral: Consult Transfer of Care				
Maternal Age: yrs LMP:	EDC:		Gesta	ational Age: wks
Non-Pregnant Consultation				
Maternal Concerns (explain):				
Fetal Concerns (explain):				
To process this referral, the follo	wing documentation	is requir	ed:	
Antenatal Records	Ultrasound Res	sults		
All relevant antenatal blood work		Reports from other specialists involved in this patient's care  Other lab tests pertinent for referral		
FTS / IPS / MSS Results	·			
Reports of abnormal findings in previous pregnancy or child (e.g. Ultrasound, autopsy, chromosomes)	Other lab tests	hermien	i ioi ie	iicii di

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