



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 Physicia	an / Midwife Information				
Name:		Phone:	()	
Address:		Fax:	()	_
Email address:	OHIP Billing No.				_
Patient	t Information				
Name:		Phone:	()	
Date of Birth:	Health Card Number:				_
Does patient need a translator? No Yes If yes	s, specify language:				_
Previous referral to another specialty in <i>this</i> pregnancy?					
Reason for Referral: Consult Transfer of Care					_
Maternal Age: yrs LMP:	EDC:		Gest	ational Age: wks	s
Non-Pregnant Consultation	-				
Maternal Concerns (explain):					
Fetal Concerns (explain):					
To process this referral, the fo	ollowing documentation	is requir	ed:		
Antenatal Records	Ultrasound Re	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	perunen	i ioi le	riciiai	

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