HIGH RISK PREGNANCY REFERRAL

St. Michael's
Inspired Care.
Inspiring Science.

Date_____

To: **MATERNAL FETAL MEDICINE DIVISION**
Dr. Berger ▪ Dr. Freire-Lizama
Dr. Chandrasekaran ▪ Dr. Lausman
61 Queen St E, 4th Floor
Toronto ON M5C 2T2

Fax: 416 864-6073
Phone: 416 867-7421 ***(Clinic)***
416 864-6060 ext 2395
(Admin office)

I would like to refer my patient to the Maternal Fetal Medicine clinic for:

☐ One-time consultation ☐ Shared care ☐ Transfer of care

Patient Contact Information: Name
Address
OHIP number
Phone number(s)

This referral is for a consultation and Obstetric ultrasound. This referral covers follow up clinic visits and repeat ultrasounds that might be needed

Clinical Information: Gravity/Parity _____EDD_____

Reason for Referral:

_____

_____

_____

_____

Note: All antenatals, ultrasounds and relevant lab results should be forwarded with the referral

Referred by: _____

_____

_____

Billing #: _____