



Patient ID

**PRENATAL CLINIC
REFERRAL FORM**

T: 416-867-7421

F: 416-867-3742

obreferral@smh.ca

Women's Health Care
61 Queen Street East, 4th floor
Toronto, ON M5C 2T2

Referral Date:

Patient Demographics:

Last Name:

First Name:

Birth Date:

SMH MRN (J#):

Primary Phone No.: ()

Alternate Phone No.: ()

OHIP No.:

- 1st Available**
 Dr. H. Berger
 Dr. N. Chandrasekaran
 Dr. T. Freire-Lizama
 Dr. S. Kives
 Dr. A. Lausman
 Dr. D. Robertson
 Dr. F. Meffe
 Dr. D. Soroka
 Dr. A. Simpson
 Dr. A. Nensi
 Dr. R. Shah
 Dr. E. Shore
 Dr. K. Tessler
 Dr. M. Yudin
 Dr. E. Mocarski
 Dr.C. McCaffrey
 Dr. S. Im (Fax: 416-977-5572)
 Dr. D. Steele (Fax: 416-864-5144)

PLEASE INCLUDE ANY ULTRASOUNDS AND RELEVANT LAB RESULTS WITH THE REFERRAL

Clinical Information	Gravity/Parity _____	Relevant History
	LMP _____	
	EDD _____	
	Antenatal bloodwork performed YES <input type="checkbox"/> (Please attach) NO <input type="checkbox"/>	

NIPT PERFORMED? YES (PLEASE ATTACH RESULT) NO

EFTS PERFORMED? YES (PLEASE ATTACH RESULT) NO (Will arrange visit at 11-13w with NT scan)

REFERRING PHYSICIAN

Referring Physician/Address (print):

Telephone:

Billing#:

Signature

Fax:

TO BE COMPLETED BY WOMEN'S HEALTH CENTRE STAFF

Appointment Booked with Dr:

Date:

Time:

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