ST. MICHAEL'S
UNITY HEALTH TORONTO

PRENATAL CLINIC REFERRAL FORM

T: 416-867-7421
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obreferral@smh.ca

7 4 0 5 9

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

Patient ID

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		Relevant History	
	Gravity/Parity _____ LMP _____ EDD_____ Antenatal bloodwork performed YES ☐ (Please attach) NO ☐		

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): Signature	Telephone: Fax:	Billing#:

TO BE COMPLETED BY WOMEN'S HEALTH CENTRE STAFF

Appointment Booked with Dr:	**Date:**	**Time:**