 **Maternity Group Referral Form**

Referring Provider Information:

|  |  |
| --- | --- |
| Name |  |
| Phone |  |
| Fax |  |
| Billing Number |  |
| Date of Referral |  |

Patient Information:

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Date of Birth |  |
| Phone Number |  |
| Health Card Number |  |

EDC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and/or LMP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients can be referred at any gestational age.

Obstetrical History:

Past Medical History:

Referring Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please include copies of ALL lab work/investigations/ultrasounds/Ontario Perinatal Records completed during the pregnancy.**

Please fax completed form to desired provider:

* Dr. Lawson: Fax: 705-320-9115 Phone: 705-320-8874
* Family Physicians: Fax: 705-324-1950 Phone: 705-324-9194
* Midwives of Lindsay and the Lakes: Fax: 705-324-4668 Phone: 705-324-4664