High Risk Pregnancy Unit

The Ottawa Hospital - Civic Campus
1053 Carling Avenue, 4th Floor, D4, Ottawa, ON K1Y 4E9
Direct 613-761-4401

Please *COMPLETE ALL OF THE FOLLOWING INFORMATION* and fax to: 613-761-5141

Referring Physician / Midwife Information

Name: ______________________ OHIP Billing Number: ______________________

Address: ____

Private Phone ______________________ Fax: ______________________

E-mail: ______________________ Date of Referral ______________________

PATIENT INFORMATION

Name: ______________________ Phone: ______________________

Date of Birth: ______________________ (YYYY · MM · DD) Health Card Number: ______________________

Does patient need a translator? ☐ No ☐ Yes Language: ______________________

Previous referral to another specialty in **this pregnancy**? Specify: ______________________

Reason for Referral: ☐ Consult ☐ Transfer of Care ☐ Shared Care ☐ Pre-pregnancy/Post Loss Consult

Maternal Age: ________yrs LMP: ______________ EDC: ______________ Gest. Age ________wks

G _____ T _____ **P** ______ **A** ______ **L** ______

Maternal Concerns: Explain: ____

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Fetal Concerns: Explain ____

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N.B. - To process referral we NEED all the following documentation with Fax.

1) **Antenatal Records 1 & 2:** Sent with faxed referral: ☐
2) **All relevant antenatal blood work:** Sent with faxed referral: ☐
3) **FTS / IPS / MSS Results:** Sent with faxed referral: ☐ or Pt. has been counseled and will ☐ or will not ☐ proceed with Integrated Pre-natal Screening
4) **Ultrasound Results:** Sent with faxed referral: ☐
5) **Reports from other specialist(s) involved in this patient's care:** Sent with faxed referral: ☐
6) **Other lab results relevant for referral:** Sent with faxed referral: ☐
7) **Reports of abnormal findings in previous pregnancy or child (e.g. Ultrasound, autopsy, chromosomes)**

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Internal Use - Date Referral Received: ______________________