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GEORGIAN RADIOLOGY CONSULTANTS

HIGH RISK PREGNANCY REFERRAL

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In collaboration with St. Michael's Hospital, University of Toronto

MATERNAL FETAL MEDICINE DIVISION

Dr. Berger Dr. Chandrasekaran Dr. Freire-Lizama Dr. Lausman

BOOKING **PHONE**# : 705 - 726 - **7442** BOOKING **FAX**# : 705 - 726 - **8056**

PATIENT CLINICAL HISTORY:

Clinical Hx must be filled out

Gravity/Parity _____ **EDD** _____

Previous Imaging? Location & Date?

PATIENT Appointment :

Date: D_____ M_____ Y_____

Time: _____ am / pm

No preparation is required.

Reason for Referral:

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

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

PATIENT INFORMATION:

DATE: D_____ M_____ Y_____ DOB: D_____ M_____ Y_____

Name: _____

Address: _____ City: _____

Home P#: _____--_____ Cell P#: _____--_____

Province: _____ OHIP# / WCB#: _____

Practitioner SIGNATURE:

_____ : Signature

_____ : Printed Name

_____ : CC Copy

REV. Jul 2018

Please bring this <u>form & health card</u> to your <u>examination</u> to avoid delay or cancellation