Sunnybrook
HEALTH SCIENCES CENTRE

DAN Women & Babies Program
Sunnybrook Health Sciences Centre
2075 Bayview Avenue,
M-wing, 4th floor
Toronto, ON M4N 3M5
Phone: 416-480-5367
Fax: 416-480-5616

Date: dd/mm/yyyy

Referral to First Trimester Anatomy Clinic

Referring Physician/midwife

Name: _____ OHIP billing#: _____

Phone: _____ Fax: _____

Email: _____ _____

Patient information

Name: _____ Date of birth: dd/mm/yyyy

Phone: _____ Fax: _____

Email: _____ Health card#: _____

EDD: dd/mm/yyyy

Relevant history: _____
_____
_____

Indication for referral:

- ☐ IVF
- ☐ ICSI
- ☐ Maternal age>40
- ☐ Previous pregnancy affected by structural / genetic anomaly (please specify): _____
- ☐ Positive FTS / NIPT
- ☐ BMI>40kg/m^2
- ☐ Pre-gestational diabetes / HbA1c>7.0%
- ☐ Known exposure to teratogenic agent (please specify): _____
- ☐ Maternal / 1st degree relative with structural / genetic anomaly (please specify): _____
- ☐ Multiple gestation
- ☐ Other (please specify): _____

Please provide all relevant documentation including laboratory results, US results, previous consultations, and previous pregnancy records.