Sunnybrook
HEALTH SCIENCES CENTRE

Women & Babies Clinic Referral Form

2075 Bayview Avenue, M-Wing, 4th floor
Toronto, Ontario M4N 3M5
Telephone (416) 480-5367

Fax to: (416) 480-5616

(Check all that apply)

Referred to: Dr. _____ ☐ High Risk Clinic ☐ Consult ☐ Transfer of Care

Referring Physician / Midwife / Nurse Practitioner

Name _____ OHIP Billing Number _____

Phone _____ Fax _____

Patient Information

Name _____ Date of Birth _____

Phone _____ Health Care Number _____

Reason for Referral

Maternal age _____ LMP _____ EDC _____ Gestational age _____ wks

☐ Maternal concerns:

☐ Fetal concerns:

To process this referral, the following documentation must be provided:

☐ Antenatal Records
☐ FTS/IPS/MSS results
☐ Reports from other specialists
☐ Ultrasound results
☐ All relevant antenatal blood work
☐ All lab tests related to referral
☐ Reports of abnormal findings in previous pregnancy or child (eg. *Ultrasound, autopsy, chromosomes*)