



MATERNAL FETAL MEDICINE CLINIC REFERRAL



MSXX104476B

REV: Sept. 10/12

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Jim Pattison Outpatient Care and Surgery Centre
9750 140th Street Surrey, B.C. V3T 0G9
Ph (604) 582-4558 EXT 763995

CENTRAL INTAKE
Fax All MFM Referrals to
(604) 582-3798

Royal Columbian Hospital
330 Columbia St E
New Westminster B.C. V3L 3W7
Ph (604) 520-4132

PLEASE COMPLETE IN FULL AND PRINT CLEARLY

Patient's Full Legal Name: _____
Last First Middle

Other Name(s) (if applicable): _____

Personal Health Number: _____ **Date of Birth:** ____/____/____ **Gender:** M F
(DD, MM, YYYY)

Address: _____
Street City Province Postal Code

Home Phone No. _____ Okay to Call **Message Phone No.** _____

Insurance Type MSP WCB Out-of-Province Self-Pay Other: _____ RCMP or Armed Forces #: _____

Interpreter Required: No Yes **Language:** _____

Age at referral:		Age at EDC:			
LMP: (DD/MM/YY)		Circle which is the final EDC		Date of earliest ultrasound: (DD/MM/YY)	
Regular cycle?		EDC by LMP: (DD/MM/YY)	EDC by U/S: (DD/MM/YY)	Gestational age at earliest ultrasound	
G	T	P	SA	TA	L
				Multiple gestation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Twins <input type="checkbox"/> Triplets <input type="checkbox"/> Other	

Reason for Referral to Maternal Fetal Medicine: (Please see reverse side for criteria details)

- Pre-pregnancy planning
- Prenatal consultation (amniocentesis, NT)
- Maternal medical condition: _____
- Prior pregnancy concern: _____
- Present pregnancy concern: _____

Additional Comments:

THE FOLLOWING RECORDS MUST BE RECEIVED TO PROCESS THIS REFERRAL

- Antenatal Record Part I and Part II (If started)
- Reports of all ultrasounds done in this pregnancy
- All available lab results; including serum integrated prenatal screen results, blood group and screen, CBC, prenatal screen, PAP smear results, FBS 2 hour OGTT (where indicated), A1C (within 3 months), electrolytes (if applicable, i.e. NVP), vaginal swabs
- All consultation reports and investigational records related to maternal diagnosis

Family Physician (if different from referring source)

Name: _____
MSP #: _____
Phone: _____ Fax: _____

Patient has no GP/NP

Referring Health Care Provider:

Name: _____
MSP #: _____
Phone: _____ Fax: _____

GP Specialist NP Hospitalist ER Other

Referring Physician Signature: _____

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