

NOTE: Incomplete and / or unsigned requisitions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

Outpatient Antenatal Consultation Request Neonatology Clinic

Please Fax To: **905-472-7534**
Paediatric Outpatient Clinics

Patient Name: _____ <small>Last First</small>
Date of Birth: _____ Sex: F M <small>Day Month Year</small>
Health Card # _____ Version Code: _____
Address: _____ Postal Code: _____
Telephone # (Best Daytime): _____
Alternate #: _____
Family Physician: _____

In this clinic, a neonatologist provides counselling to expectant parents (planning to deliver at Markham Stouffville Hospital) regarding anticipated newborn complications and attempts to prepare them for their newborn's expected postnatal course.

The clinic schedules virtual consultation (for outpatients) or in-person consultation (for inpatients).

For inpatient consultations, please contact Neonatologist on-service.

Date	Requesting Physician/Registered Midwife	Signature of Physician/Registered Midwife
Billing #	Telephone	Fax

Spoken Language if other than English. **Please bring translator to the appointment if required.**

Reason for consultation:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Maternal SSRI Use | <input type="checkbox"/> ITP | <input type="checkbox"/> SLE/Collagen Vascular Disease | <input type="checkbox"/> Previous preterm delivery |
| <input type="checkbox"/> Maternal Narcotic Use | <input type="checkbox"/> IUGR | <input type="checkbox"/> Chromosomal abnormality | <input type="checkbox"/> Previous pregnancy complication |
| <input type="checkbox"/> Graves Disease | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Abnormal dopplers | <input type="checkbox"/> Suspected congenital abnormalities
(as per anatomy ultrasound) |
| <input type="checkbox"/> Hereditary condition | <input type="checkbox"/> Fetal Renal abnormalities/pelviectasis | | |
| <input type="checkbox"/> Other: _____ | | | |

Other Clinical Information:

Please ensure the following are included with this request:

- Ontario Antenatal Records
- If applicable: Radiology results Lab Results Other consult reports

Please fax request and accompanying information to Paediatric Outpatient Clinics at 905-472-7534