

CENTRAL INTAKE – Obstetric Referral

Fax: (905) 472-7625

To expedite your referral, please ensure this form is completed and all supporting documents attached

Select Provider for Care	
<input type="checkbox"/> Preferred Doctor 1. _____	<input type="checkbox"/> Uxbridge Community Midwives
<input type="checkbox"/> Preferred Doctor 2. _____	<input type="checkbox"/> Midwifery Services of Durham
<input type="checkbox"/> First Available Doctor	<input type="checkbox"/> Markham Stouffville Midwives

Patient Information				
Patient Name: (Last, First)			Date of birth: (dd/mm/yyyy)	
Main Telephone:			Alternative phone number:	
Address:	Street	City	Prov	Postal Code
Health Card Number:			Version Code:	

Referring Health Care Provider				
Physician Name: (Last, First)			Physician Signature	
Telephone Number:			Fax Number:	
Address:	Street	City	Prov	Postal Code
Billing #:				

Patient Pregnancy Information		
First day of LMP: (dd/mm/yyyy)	EDD Date : (dd/mm/yyyy)	Gestational Age

Supporting Documents Included			
<input type="checkbox"/> Ultrasounds	<input type="checkbox"/> Specialists Reports	<input type="checkbox"/> Antenatal Forms	<input type="checkbox"/> Blood Work
<input type="checkbox"/> First Trimester Screening	<input type="checkbox"/> Integrated Prenatal Screening	<input type="checkbox"/> Assisted Reproductive Reports	<input type="checkbox"/>
<input type="checkbox"/> Other Consult reports if applicable: _____			

Additional Comments

Please note: Your patient will be contacted directly with appointment information