Thamesview
MATERNITY CARE GROUP

Referral Form: DATE COMPLETED ________________

Patient Name		Referring Provider:
DOB		Provider Phone #:
Address		Provider Fax #: (or stamp)
Phone #		Primary Care Provider: (if different from above)

*Patient Label with above information is accepted

Obstetrical History: G __ T ___ P ___ A ___ L ___		**EDC:**	**LMP:**
Special notes/Comments			
If completed, please attach Antenatal 1 and 2 + lab/ultrasound results.			

Below investigations not required prior to referral, but part of the routine investigations we will order:

- ☆ Prenatal: ABO, RhD, Antibody Screen; CBC; TSH; Urinalysis; Urine Culture
- ☆ With Public Health Form: HIV, Hep B, VDRL, Rubella, Gonorrhea/Chlamydia (urine or cervix)
- ☆ Pap Smear only if due for this/appropriate
- ☆ Dating Ultrasound as per updated SOGC guidelines

We are a group of Family Physicians providing antenatal, intra-partum and post-partum obstetrical care within Chatham-Kent. Referral made to:	
Next Available Physician ☐	Dr. Kate Bailey ☐
	Dr. Lindsey Sutherland ☐
	Dr. Jacqueline Wolting ☐
Patients may be referred any time between 12 and 32 weeks of pregnancy. All patients will be returned to the care of their Family Physician/Nurse Practitioner after delivery.	

FAX COMPLETED FORMS TO 519 354 6132

Thank-you for the referral!

We are located at the Thamesview Family Health Team, Chatham, Ontario

www.thamesviewfht.ca