



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. Jacqueline Wolting

Dr. Lindsey Sutherland

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

465 Grand Ave West

Chatham, Ontario

www.thamesviewfht.ca