REFERRAL FORM

FAMILY PHYSICIAN OBSTETRICS | LOW-RISK PRENATAL + DELIVERY CARE

IMPORTANT:

- Please send your referrals AS EARLY IN PREGNANCY AS POSSIBLE if you do not plan to provide prenatal care
- We ONLY DELIVER at the ROYAL ALEXANDRA HOSPITAL
- We do not accept patients without Alberta Healthcare or IFH funding
- Comprehensive pregnancy care (eg. completed Alberta Prenatal Record) must be included for referrals greater than 26 weeks gestation

Please fax completed form to MOM CARE DOCS | Allin Clinic | Fax 780 488 2056

Date of referral

REFERRING PHYSICIAN						
Name		Clinic		Practice ID		
Address	Postal Code	Phone				
City		Province	Fax			
PATIENT INFORMATION						
First Name Last Name		e		DOB (MON-DD-YYYY)		
Address		Postal Code		Personal Healthcare Number		
City	Province		Phone			
Language Barrier?	Alternate Phone					
\Box No \Box Yes \rightarrow Language required?						
Previous Mom Care Docs Patient?						
🗆 No 🛛 Yes						

PLEASE COMPLETE PAGE 2 – PATIENT MEDICAL HISTORY

PLEASE ENSURE THE FOLLOWING HAS BEEN COMPLETED BEFORE SENDING REFERRAL						
Tests	Requisition					
\Box CBC, Ferritin, TSH, Hemoglobinopathy, Urine R+M	General Laboratory					
□ Chlamydia + Gonorrhea, Urine C+S	ALBERTA PRECISION LABORATORIES Leaders in Laboratory Medicine Alberta Precision Laboratories 1-877-866-8640 Appointment Booking & Locations: www.albertaprecisionlabs.ca					
□ Hep B SAb, HIV, Syphilis, Rubella IgG, Varicella IgG,	ALBERTA ALBERTA PRECISION LABORATORIES Lauters 1: Lauters 1: Lauters 1:	ctious Disease Panel				
□ ABO, Rh, Antibodies	Canadian Blood Services	Perinatal Testing For Red Blood Cell Serology				
□ 1 st trimester/Dating Ultrasound (CRL > 10mm for accurate EDC)						
\Box GREATER THAN 26 weeks gestation - MUST also include:						
Completed Alberta Prenatal Record – all relevant labs/exams MUST BE entered	At this late gestational age we require this information to appropriately assess your patient's pregnancy risk factors.					
Gestational Diabetes Screen results	••••	ailure to provide this information will result in a decline of				
□ 18-20w Obstetrical Anatomy U/S results	referral.					





PATIENT MEDICAL HISTORY

First Name	irst Name Last Name			DOB (MON-DD-YYYY)						
CURRENT PF	REGNANC	Y								
EDD (MON-DD-YYYY) DBy LMP			LMP (MON-DD-YYYY)		Current Gestational Ag			Gravida	Parity	
🗆 By U/S										
Previous Caesa	arean Sectio	on(s)?								
□ No □ Y	/es → How n	nany C-secti	ons?	(If more than 1 >	C-Se	ction, plea	ise refer	to OB)		
Weight	Height	BMI	BMI			Date:				
kg		cm	(If >45, please refer to OB)			(If pt hx of HTN, please refer to Of				r to OB)
Medication List	(including	dose and fre	queno	cy):						

MEDICAL HISTORY (including complications in previous pregnancies)						
MEDICAL HX	OTHER MEDICAL HX					
Pre-existing Type 1 or 2 Diabetes						
Chronic Hypertension						
Hx of Seizures/Epilepsy						
Kidney Disease						
Pre-Pregnancy BMI > 45						
OBSTETRICAL HX						
More than 1 Previous Caesarean Section	PERTINENT SOCIAL HX / SUBSTANCE USE					
Preterm Delivery before 34wk Gestation						
Current Twin/Multigestational Pregnancy						
Current Illicit Drug Use/High Risk Behaviours						
If ANY of the above are true this patient is						
considered HIGH RISK. Please refer to an						
obstetrician.						

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