IWK Health

# Referral for Maternal Fetal Medicine (MFM) Ultrasound Consultation Fetal Assessment and Treatment Centre (FATC)

**Phone: (902) 470–6654 Fax: (902) 470–7987**

**Please Complete All Fields (if the referral is incomplete, it may result in delays of time sensitive ultrasound)**

Patient Name ____________________ Lived Name ____________________

Address ____________________ Pronoun ____________________

____________________ DOB (yyyy/MON/dd) ____________________

❑ Interpreter Required HCN ____________________

Language: ____________________ Phone Number ____________________

Referring Care Provider ____________________

Gravida _____ Para ______ Abortus _______

LMP (yyyy/MON/dd) ____________ Dates certain? ❑ Yes ❑ No EDC (yyyy/MON/dd) ____________

Has an ultrasound been performed in this pregnancy? ❑ Yes ❑ No

**If 'Yes':**

Date of U/S (yyyy/MON/dd) ____________ Gestational Age at U/S _______ weeks _______ days

**** Attach copies of all ultrasounds (including dating and 20 week anatomy) ****

Has MST been performed? ❑ Yes ❑ No **** Attach Report**

Has NIPT been performed? ❑ Yes ❑ No **** Attach Report**

Patient Weight ________ BMI ________ Blood Type ________ **** Please attach copy of blood type**

**Indication(s) for Referral:**

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## For FATC Use Only

Date Referral Received (yyyy/MON/dd) ____________________

Triage Date (yyyy/MON/dd) ____________________

❑ **Dating / Viability** ❑ **Echo** ❑ **Transvaginal Ultrasound**

❑ **Clinic Dopplers** ❑ **Anatomy** ❑ **Early Pregnancy Review**

❑ **Multiples** ❑ **Growth** ❑ **BPP**

Appointment Date ____________ (yyyy/MON/dd) Time (24 hour clock) __________

❑ Physician Notified ❑ Patient Notified

Date of Notification(yyyy/MON/dd) ____________

Method of Notification: ❑ Phone ❑ Fax ❑ Other

**Patient to be seen:** ❑ ASAP

❑ within ____ Days ❑ within ____ Weeks

**Patient to be seen at:** ______weeks = ________ (yyyy/MON/dd)

Between ____________ (yyyy/MON/dd) and ____________ (yyyy/MON/dd)

FATC Physician Comments

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❑ FATC not indicated

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