



**Fetal Assessment & Treatment Centre (FATC)
Referral for Maternal Fetal Medicine (MFM)
Ultrasound Consultation**

Main Phone: (902) 470-6654
Booking Office Phone: (902) 470-6461
Main Fax: (902) 470-7987

Appointment Date: _____
Appointment Time: _____

- Please complete all fields. Incomplete referrals may result in delays or inability to complete time sensitive ultrasounds.
- For MFM consultation regarding pregnancy care OR requests for ongoing prenatal care, do not use this form. Please fill out & fax a referral to the IWK Perinatal Centre (PNC).
- For MFM questions, do not use this form. Please call the MFM on-call via IWK Switchboard.

Patient Name _____ Lived Name _____ Pronouns _____
 DOB (yyyy/MON/dd) _____ Provincial HCN _____ Province _____
 Address _____ Does **not** have Canadian HCN (ex: self-pay)
 _____ Student with valid insurance
 Phone Number _____ Interpreter Required - language: _____

Referring Care Provider _____ Care provider phone number _____
 Prenatal Care Provider (if different) _____ Care provider fax number _____

Gravida _____ Para _____ Abortus _____ Patient weight _____ or BMI _____
 Best estimate of EDD (yyyy/MON/dd) _____ Blood type _____ (please attach blood type report)
 Based on: IVF: day ___ embryo transfer date: _____ Genetic screening/ MST PGS / PGT
 LMP: _____ Certain/regular cycles? Yes No testing completed: NIPS Amnio / CVS
 Dating ultrasound: fill in details below / attach report Declined

Dating US Details (first US after 7 weeks' gestation; required for EPR/NT referrals for patients living outside Halifax County)
 Date of US (yyyy/MON/dd) _____ Gestational age at US _____ weeks _____ days CRL _____ mm

Indication(s) for Referral:

- Virtual Image Review (state indication above; images need to be uploaded to PACS if US completed outside NS)
 New Brunswick patient requiring second opinion vs. relocation for delivery

For FATC Use Only

Date referral received: _____ Date referral triaged: _____	Patient to be seen: <input type="checkbox"/> Within _____ days <input type="checkbox"/> ASAP <input type="checkbox"/> Within _____ wks <input type="checkbox"/> At _____ wks = _____ <input type="checkbox"/> Between _____ and _____
<input type="checkbox"/> Dating / viability <input type="checkbox"/> Cardiac <input type="checkbox"/> Transvaginal <input type="checkbox"/> Clinic Dopplers <input type="checkbox"/> Anatomy <input type="checkbox"/> EPR <input type="checkbox"/> Multiples <input type="checkbox"/> Growth <input type="checkbox"/> BPP <input type="checkbox"/> Amnio <input type="checkbox"/> Growth Plus <input type="checkbox"/> FGR <input type="checkbox"/> CVS <input type="checkbox"/> Virtual Review <input type="checkbox"/> Other:	FATC Comments: <input type="checkbox"/> FATC not indicated or not possible _____ _____ _____ _____
Date of notification: _____ <input type="checkbox"/> Care provider notified <input type="checkbox"/> Patient notified Method of notification: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Other _____	