IWK Health

Referral to the IWK Perinatal Centre

Phone: (902)470-6445
Fax: (902)470-7467

******* ALL FIELDS MUST BE FULLY COMPLETED LEGIBLY *******

Patient Name: _____ DOB (dd/mm/yyyy): _____

Address: _____

Phone # (home/cell): _____ HCN ***(Identify Province)***: _____

Referral to: Obstetrics ❑ Family Medicine ❑ Specific Physician _____

Out-of-Country Patient: Yes ❑ No ❑ Insurance: No Insurance ❑ Private Insurance ❑ Cash pay ❑

Gravida ❑ Para ❑ Abortus ❑ LMP (dd/mm/yyyy)_____ Dates Certain: Yes ❑ No ❑

Ultrasound performed in this pregnancy? Yes ❑ No ❑ **If Yes, please attach copy of ultrasound**

- **Uncertain dates, or irregular menstrual cycles**: Confirm that a dating ultrasound has been ordered / performed. Yes ❑
- **35 years at delivery**: Has an Early Pregnancy Review been required / performed if the patient wishes screening for Trisomy 21? Yes ❑ No ❑ **FATC Information: Phone (902)470-6461 Fax (902)470-7987**

- Would the patient like to be seen at the PNC satellite clinic at the Cobequid Centre? Yes ❑ No ❑

Additional information for referral (additional pages may be attached): _____

_____

_____

Please include the following:	**Yes**	**Not Available**
Pregnancy laboratory investigations as recommended by the Reproductive Care Program of Nova Scotia: http://rcp.nshealth.ca/chart-pre-natal-forms	❑	❑
Maternal Serum Screen (MSS) Final Report	❑	❑
Previous consultation letters, if applicable	❑	❑

Is an interpreter required? Yes ❑ Language: _____

Until the time of patient's initial appointment in PNC please continue to provide care

Referring Physician/Midwife/NP Signature	Print Name	Billing #	Date: (dd/mm/yyyy)

******* For Booking/Triage Use Only *******

Date referral received (dd/mm/yyyy)_____	Physician Notified: ❑ Date Notified (dd/mm/yyyy) _____
Triage Date (dd/mm/yyyy) _____	Method of Notification: Phone ❑ Fax ❑ Other ❑
Patient to be seen: ASAP____ Days____ Weeks____	Patient Notified: ❑ Date Notified (dd/mm/yyyy)_____
Appointment Date/Time _____	Method of Notification: Phone ❑ Fax ❑ Other ❑