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 (YYYY/MON/DD): _____

Appointment Time (HH:MM): _____

- **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 and 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: _____
Date of Birth (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 Healthcare Provider: _____
Healthcare provider phone number: _____
Prenatal Care Provider (if different): _____
Healthcare 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: _____ (YYYY/MON/DD)
❑ LMP: _____ Certain/regular cycles? ❑ Yes ❑ No
❑ Dating ultrasound: fill in details below/attach report

Genetic screening/testing completed:
❑ Maternal Serum Testing
❑ Non-invasive Prenatal Screening
❑ Declined
❑ Pre-implantation Genetic Screening
❑ Amnio/Chorionic Villus Sampling (CVS)

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

Indication(s) for Referral:

_____
_____
_____
_____
_____
_____

❑ Virtual Image Review (state indication above; images need to be uploaded to PACS if U/S completed outside Nova Scotia)
❑ New Brunswick patient requiring: ❑ Second opinion vs. ❑ Relocation for delivery

For FATC Use Only

Date referral received (YYYY/MON/DD): _____
Date referral triaged (YYYY/MON/DD): _____

❑ Dating/viability ❑ Cardiac ❑ Transvaginal
❑ Clinic Dopplers ❑ Anatomy ❑ Early Pregnancy Review
❑ Multiples ❑ Growth ❑ Biophysical Profile
❑ Amnio ❑ Growth Plus ❑ Fetal Growth Restriction
❑ CVS ❑ Virtual Review ❑ Other: _____

Date of notification (YYYY/MON/DD): _____
❑ Healthcare provider notified ❑ Patient notified
Method of notification: ❑ Phone ❑ Fax ❑ Other: _____

Patient to be seen:
❑ Within _____ days ❑ ASAP
❑ Within _____ weeks ❑ At _____ weeks = _____
❑ Between _____ and _____

FATC Comments:
❑ FATC not indicated or not possible
_____
_____
_____
_____
_____