Maternal-Fetal Medicine
Kingston General Hospital
76 Stuart Street, Kingston, Ontario K7L 2V7
☎ (613) 548-6072

Please complete all of the following information and fax to: (613) 548-1330

Referring Physician / Midwife Information

Name: ____ Hospital: _________________________

Phone: _______________________ Fax: _______________________________

E-mail:____

Patient Information

Name: ____ Phone: ____________________________

Date of Birth: __________________________________ Health Card Number: _____________________________
YYYY · MM · DD

Does patient need translator? ☐ No ☐ Yes Language: ____

Previous referral to another specialty in ***this*** pregnancy? Specify: ____

Reason for Referral: ☐ Consult ☐ Transfer of Care ☐ Non-Pregnant Consultation

Maternal Age: ______ yrs LMP:________________EDC: ___________________ Gest. Age _________ wks

For patients in the first trimester:
Date of nuchal translucency ultrasound: _____________________

Maternal Concerns:

Fetal Concerns:

To process this referral, the following documentation is required:

- Antenatal Records
- All relevant antenatal blood work
- PAP and cervical/vaginal swabs
- FTS / IPS / MSS Results
- Ultrasound Results
- Reports from other specialists involved in this patient's care
- Other lab tests pertinent for referral
- Reports of abnormal findings in previous pregnancy or child *(e.g. Ultrasound, autopsy, chromosomes)*

Please continue to provide care for your patient until seen by Maternal Fetal Medicine.

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