

Please complete and fax to: 613-548-1330



## Maternal Health Clinic Referral Form

### Referring Health Care Provider

HCP Name:	_____
Location:	_____
Phone:	_____ <i>private / direct line</i>
Fax:	_____
Email:	_____

### Patient Information

Patient Name:	_____
OHIP Number:	_____
Phone:	_____ <i>(work / home / cell)</i>
Date of Birth:	_____
Date of Delivery:	_____

### Reason for Referral:

- Preeclampsia, eclampsia or HELLP Syndrome
- Gestational Hypertension
- Gestational Diabetes
- IUGR baby, <5th%ile for gestational age at <37 weeks or <2500g baby at ≥37 weeks
- Idiopathic Preterm birth (< 37 weeks)
- Placental abruption leading to delivery for either maternal or fetal reasons
- Other:

#### Maternal Health Clinic Contact Information:

Michelle Roddy, Clinic Coordinator and Nurse  
613-549-6666 x2740

[Michelle.Roddy@Kingstonhsc.ca](mailto:Michelle.Roddy@Kingstonhsc.ca)

Dr. Graeme Smith, Attending Physician

[gns@queensu.ca](mailto:gns@queensu.ca)