*NOTE: Incomplete and / or unsigned requistions will be returned*

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

# OBSTETRICAL CLINIC REFERRAL

Markham Site Booking Line: **(905) 472-7534**

Please Fax To: **(905) 472-7535**

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name: ______________________
Last First

Date of Birth: ______________________ Sex: F M
Day Month Year

Health Card # ____________ Version Code: ________

Address: ______________________ Postal Code: ________

Telephone # (Best Daytime): ______________________

Alternate #: ______________________

Family Physician: ______________________

| **Date** | **Referring MD** | **Signature** |
|---|---|---|
| | | |

| **Billing #** | **Telephone** | **Fax** |
|---|---|---|
| | | |

| **Address** | **City** | **Postal Code** |
|---|---|---|
| | | |

Additional Reports to:

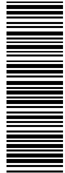
Spoken Languange if other than English. **Please bring translator to the appointment if required.**

**Request for**

☐ Early Pregnancy Assessment ☐ Postpartum Assessment ☐ Breastfeeding Assessment

**Reason for Referral**

**Past Medical History**



**Current Medications**

**Tests required**

☐ Beta HCG

☐ Pelvic ultrasound

*** Please attach any recent blood work or ultrasounds ***