CENTRAL INTAKE – Obstetric Referral

FAX: 1-855-346-9138

To expedite your referral, please ensure this form is completed and all supporting documents attached

Select Provider for Care	
❒ Preferred Doctor 1. _____	❒ Uxbridge Community Midwives
❒ Preferred Doctor 2. _____	❒ Midwifery Services of Durham
❒ First Available Doctor	❒ Markham Stouffville Midwives

Patient Information				
Patient Name: (Last, First)			Date of birth: (dd/mm/yyyy)	
Main Telephone:			Alternative phone number:	
Address:	Street	City	Prov	Postal Code
Health Card Number:			Version Code:	

Referring Health Care Provider				
Physician Name: (Last, First)			Physician Signature	
Telephone Number:			Fax Number:	
Address:	Street	City	Prov	Postal Code
Billing #:				

Patient Pregnancy Information		
First day of LMP: (dd/mm/yyyy)	EDD Date : (dd/mm/yyyy)	Gestational Age

Supporting Documents Included			
❒Ultrasounds	❒ Specialists Reports	❒ Antenatal Forms	❒ Blood Work
❒ First Trimester Screening	❒ Integrated Prenatal Screening	❒ Assisted Reproductive Reports	❒
❒ Other Consult reports if applicable: _____			

Additional Comments
_____
_____

Please note: Your patient will be contacted directly with appointment information

381 Church Street, PO Box 1800, Markham, ON L3P 7P3

Tel: 905-472-7373 ext. 7019