NEONATAL FOLLOW UP CLINICS REFERRAL

Telephone: 905.472.7534
Please Fax To: (905) 472-7535

☐ **Neurodevelopmental Follow Up with EIS**
☐ **NICU Follow Up**

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name: ______________________ (Last) (First)
Date of Birth: ______________________ (Day) (Month) (Year) Sex: F M
Health Card # ______________ Version Code: __________
Address: ______________________ Postal Code: __________
Telephone # (Best Daytime): ______________________
Alternate #: ______________________
Family Physician: ______________________

Referral Source/MD	**Referral Phone #**	**Expected Date of Confinement**
Parent/Guardian Name		**Phone #**
Reason for Referral		

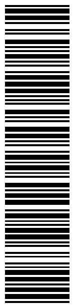
Desired Appointment Date: In ______ weeks / In ______ months **OR** Date: ____________

Gestational Age (GA): ___________ weeks ☐ AGA ☐ SGA (< 3rd percentile birth weight) ☐ ≥ 1,500 gm ☐ ≤ 1,500 gm
Apgar Scores: _____ 1 min _____ 5 min _____ 10 min ☐ Single ☐ Twin ☐ Triplet ☐ Quad
Birth Weight _______ grams ☐ Syndrome/Disorder: ______________

☐ All head ultrasound normal? ☐ Yes ☐ No
☐ Head ultrasounds not done ☐ MRI/CT scan(s): ____________________
☐ Most recent head ultrasound: ______________________

☐ Family history of developmental delays, learning disabilities, language disabilities, ADHD, PDD/ASD, hearing impairment

CENTRAL NERVOUS SYSTEM
- ☐ Head circumference < 3%
- ☐ Periventricular (PV) echoes/flares
- ☐ Any meningitis except staph epidermidis
- ☐ Grade I or II IVH, SEH haemorrhage or cysts, Germinal Layer haemorrhage
- ☐ Hemorrhagic infarct; porencephalic cysts, parenchymal extension
- ☐ Ventriculomegaly (persistent ventricular dilatation)
- ☐ Neonatal seizures
- ☐ Grade III or IV IVH
- ☐ PVL; porencephaly
- ☐ Hydrocephalus
- ☐ Diagnosis of CP
- ☐ Stroke



HEMATOLOGIC
- ☐ Jaundice / Hyperbilirubinemia (Exchange Level)
- ☐ Jaundice requiring exchange transfusion
- ☐ Thrombocytopenia
- ☐ Anemia requiring transfusion

CARDIAC
- ☐ Patent Ductus Arteriosus (PDA) ☐ CHD
  - ☐ Surgery ☐ No Surgery
- ☐ Atrial Septal Defect (ASD) ☐ Ventricular Septal Defect (VSD)

EYES
- ☐ Retinopathy of Prematurity (ROP): Stage _____ Zone _____

GASTROINTESTINAL
- ☐ Necrotizing Enterocolitis (NEC)
  - ☐ Surgery ☐ No Surgery

RESPIRATORY
- ☐ Respiratory Distress Syndrome (RDS)/ Hyaline Membrane Disease
- ☐ Ventilated +/- low flow oxygen less than 36 weeks GA
- ☐ Persistent Pulmonary Hypertension of the Newborn (PPHN)
- ☐ Pneumothorax/Pneumothoraces
- ☐ Severe Bronchopulmonary Dysplasia (BPD) or Chronic Lung Disease (CLD)

Comments:

Name	Signature	Date