



Old South Maternity Care Referral Form

208-190 Wortley Rd., London ON, N6C 4Y7

Tel: (519) 438-5101 Fax: (519) 438-0369

www.oldsouthmaternity.ca

Patient Label

(including OHIP number)

Physician's Stamp

(including OHIP billing number)

Please indicate your physician preference:

- Earliest available
- Dr. C. Smits
- Dr. L. Dales
- Dr. P. Hacking
- Dr. C. Thompson
- Dr. E. Bachmeier

Clinical info:

LMP: _____

EDD: _____

GTPAL: _____

Number of previous C-sections: _____

Timing of first visit with us:

- Early referral / as soon as possible
- Shared care – transfer prenatal care at: _____ weeks Gest. Age.

Are you part of a FHT/FHO?

- Yes
- No

Will you be resuming care after the post-partum period?

- Yes
- No

Please attach Antenatal Records, relevant patient information, and test results (prenatal screening, labs tests, ultrasounds) and fax referrals to (519) 438-0369

Referring Physician's Name

Signature

Date