DATE OF FAX:	DATE RECEIVED:

LOW RISK OBSTETRICS FAMILY MEDICINE PRENATAL CLINIC
MARION MEDICAL CENTRE

Dr. V. Demers, Dr. D. Houle, Dr. S. Lee, Dr. K. Magsino

172 Marion St
Winnipeg MB
R2H 0T4

REFERRING PROVIDER INFO:

Provider Name: ______________________

Clinic/Hospital: ______________________

Address: ___________________________

Phone Number: ______________________

Fax Number: ________________________

PATIENT INFO: PHIN: ______________

Patient Name: ______________________

Date of Birth: ______________________

Address: ___________________________

Phone Number: ______________________

Alternate Phone: ____________________

OBSTETRICAL HISTORY:

G: _____ P: _____ SA: _____ TA: _____

LMP: __________________ ☐ Unknown

EDD: Day _____Month _____ Year _____

Ultrasound Reports: *See attached:* ☐
1st trimester: YES ☐ NO ☐ Ordered ☐
20 wk routine: YES ☐ NO ☐ Ordered ☐

Comment: __________________________

Relevant Lab Results: ___________________
See attached: ☐

Medical History: ______________________
See attached ☐

Allergies: ___________________________
See attached ☐

Medications: _________________________
See attached ☐

ADDITIONAL INFORMATION:

I will provide care for newborn at 1-2 weeks once discharged from hospital: YES ☐ NO ☐
I will provide care for newborn at 6-8 weeks when mother returns to my care: YES ☐ NO ☐

Please provide a brief summary of the reason for referral and any specific concerns or consideration

Referring Provider's Signature: ______________________ Date: ______________