Referring Doctor: _____ CPSO#: _____

Grand River Hospital

Childbirth Program

Phone: 519-749-4300 Ext: 2260

This referral form used for pregnant women without a family physician

Notification of Referral

Date: _____

Patient name: _____

DOB: _____

LMP: _____

☐ URGENT REFERRAL IF GREATER THAN 36 WKS

Health card #: _____

Phone #: _____ Alternative: _____

Please make sure both numbers are working and receiving messages.

Instructions:

1. **Complete referral and fax to Childbirth program. Fax # 519-749-4433**
2. **GRH Childbirth program will notify the next OB/Family physician on roster**
3. **OB/Family physician will contact patient with appointment date and time.**
4. **PLEASE NOTE: Referring physician is responsible for all diagnostic tests (laboratory, ultrasound) until the patient is seen by the consultant**

GRH Clerical Staff Only

Doctor: _____

Fax #: _____

Faxed Date: _____

Patient Contacted ☐ **YES**

Secretary Initials: _____