

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: _____

Attention: This facsimile transmission (fax) is intended for use only by the addressed named below. If you are not the intended recipient, or the employee or agent responsible for delivering messages to the intended recipient, you are hereby notified that any dissemination, copying or disclosure of the contents of this fax is strictly prohibited. If you receive this fax in error, notify the sender by telephone immediately and either destroy the original fax, or return it to the sender by mail. Your cooperation is sincerely appreciated.