William Osler Health System

Peel Memorial Centre for Integrated Health and Wellness
20 Lynch St, Brampton, ON L6W 2Z8
Phone: 905-863-2552
Fax: 905-863-2468

Patient Identification

Maternity Care Clinic
REFERRAL FORM

Service Information

Referral Source ☐ Emergency Department/ UCC ☐ Acute Care ☐ Primary Health Care ☐ Other _____

The clinic provides patient and family-centered prenatal and postpartum care to women, and we have special services for those experiencing psychosocial challenges and/or mental health concerns. The inter-professional team is comprised of family physicians providing low risk obstetrical care, nurses and a social worker. Women attend the clinic for their prenatal appointments with the intent to deliver at BCH. We promote shared decision-making and encourage women's active participation in all aspects of their care. Women are also able to self-refer by calling the clinic or faxing this form. Postnatal services, including breastfeeding support and newborn care, are also available to ensure mothers and babies are well supported in the days following delivery. Clients will receive a phone call within 48 hours, to further discuss their needs and make appropriate recommendations and referrals.

Patient Information

Patient's Last Name: _____ **Patient's First Name:** _____

Date of Birth: (DD/MM/YY) _____ **Gender:** ☐ Male ☐ Female ☐ Other

Health Card Number: _____ **Version:** _____ **No OHIP:** ☐

Address: _____ **City:** _____ **Province:** _____ **Postal Code:** _____

Phone # (primary): _____ **Phone # (alternate):** _____ **Cell #:** _____

Patient's E-mail: _____ ☐ **Interpretation Services Required; Language:** _____

Person to contact for booking appointment *(If different than patient):* _____

Relationship to patient: _____

Reason for Referral & Relevant Patient History

G__T__P__A__L__

Date of (if known)

LMP: _____

EDC: _____

Are there any mental health and/or psychosocial concerns? ☐ Yes ☐ No

_____

_____

Are there any medical or pregnancy concerns? ☐ Yes ☐ No

_____

_____

Please forward all laboratory tests, ultrasounds and genetic screening if done.
We encourage patients be referred early to take full advantage of genetic screening and preventative care.
All patients will return to their primary care physician post-partum.

Referring Clinician Information

Referring Clinician Name: _____ **OHIP Billing Number:** _____

Phone #: _____ **Fax #:** _____ **E-mail:** _____

Family Physician *(If different from above)*: _____

Signature of Referring Clinician: _____ **Referral Date:** _____

Patient Self-Referral Family Doctor's Name: _____ ☐ I do not have a family doctor

Clinic Use Only

Date Referral Screened: _____

Date Appt. Booked: _____

Date of Appt.: _____

Referral Received Actions:

- ☐ Approved
- ☐ Patient Declined
- ☐ Redirected to _____
- ☐ Other _____

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03^1 of 1