# Summerside Obstetrical Referral Form

# Fax to: 902-288-1512 Email to: summersideobsgynereferrals@ihis.org

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| **Referral to:**   * **Next available appointment** * Dr. Beth Barbrick-Crozier * Dr. Hani Farag * Dr. Brianne Lewis * Dr. Akin Ojuawo |
| **Type of Referral:**   * Consult * Consult and Transfer of Care |

*Please be advised that while requests are taken into consideration there is no guarantee the request will be accommodated. Priority for requests will be given based on triaged determination of level of urgency and to those who have a pre-existing physician-patient relationship (prior pregnancy, prior gynecologic care)*

**Please complete in full:**

*Be aware that if relevant items are missing, triage will be delayed until the referral is complete.*

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| **Patient Information** | | | |
| **First Name:** | **Last Name:** | **DOB (YYYY/MM/DD):** | **PHN:** |
| **Preferred Pronoun:**  He/Him  She/Her  They/Them | **If Minor, consent to contact parent with appointment**  Yes No | **Phone #:** | **Alternate Phone#:** |
| **Address:** | **City:** | **Province:** | **Postal Code:** |
| **Email address:** | **English first language:**  Yes No | **Interpreter required:**  Yes No | **Accessibility Needs:** |
| **Other:** |
| **Patient History** | | | |

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| Age at Referral: Age at EDC: | | | | | | | | | |
| LMP: (*YYYY/MM/DD*):  Regular Cycle?  Yes  No  Best EDC? (*YYYY/MM/DD*): | | | | | | | | | Date of earliest Ultrasound: (*YYYY/MM/DD*):  Gestational Age at earliest ultrasound: |
| G | P | T | SA | TA | Prem | IUGR | NND | L | Multiple gestation: Yes No  Twins  Triplets  Other |
| Reason for referral:  Pre-Pregnancy planning  Pregnancy  Post-Partum | | | | | | | | | |
| Reason for Referral Comments: | | | | | | | | | |
| Recent relevant documents to be forwarded along with referral (send all except prenatal record @ 28 weeks if **not** early referral):   * Prenatal Record- PEI Reproductive Care Program (Completed; white, pink & canary copies if after 28 weeks) * Reports of all diagnostics that support or are related to the reason for referral or  **Ordered Pending** * Lab results obtained related to this pregnancy or  **Ordered  Pending** * All consultant reports and investigational records related to maternal diagnosis/medical diagnosis | | | | | | | | | |

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| **Referring Physician/Nurse Practitioner  Unaffiliated Patient** | |
| **Name:** | **Date of Referral:** |
| **Phone #**  **Email** | **License #** |

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| **OBGYN Office use only: To be completed by Triage Physician** |
| **Referral:**  Accepted  Needs more Information:  Declined: |
| **Triage Grading:**  < 2 weeks  < 6 weeks  6 weeks-3 months  3-6 months  6-12 months |
| **Surgical intervention likely needed:**  Yes  No |
| **Triage Physician signature:**  **Date:** |

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