Fetal Assessment & Treatment Centre (FATC)
Referral for Maternal Fetal Medicine (MFM)
Ultrasound Consultation

Main Phone: (902) 470-6654
Booking Office Phone: (902) 470-6461
Main Fax: (902) 470-7987

Appointment Date:_____

Appointment Time: _____

- **Please complete <u>all</u> fields. Incomplete referrals may result in delays or inability to complete time sensitive ultrasounds.**
- **For MFM consultation regarding pregnancy care OR requests for ongoing prenatal care, do <u>not</u> use this form. Please fill out & fax a referral to the IWK Perinatal Centre (PNC).**
- **For MFM questions, do <u>not</u> use this form. Please call the MFM on-call via IWK Switchboard.**

Patient Name _____
DOB (yyyy/MON/dd) _____
Address _____
_____
Phone Number _____

Lived Name _____ Pronouns _____
Provincial HCN _____ Province _____
☐ Does **not** have Canadian HCN (ex: self-pay)
☐ Student with valid insurance
☐ Interpreter Required - language: _____

Referring Care Provider _____
Prenatal Care Provider (if different) _____

Care provider phone number _____
Care provider fax number _____

Gravida _____ Para _____ Abortus _____
Best estimate of EDD (yyyy/MON/dd) _____
Based on: ☐ IVF: day ___ embryo transfer date: _____
☐ LMP: _____ Certain/regular cycles? ☐Yes ☐No
☐ Dating ultrasound: fill in details below / attach report

Patient weight _____or BMI _____
Blood type _____ (please attach blood type report)
Genetic screening/ testing completed: ☐ MST ☐ PGS / PGT ☐ NIPS ☐ Amnio / CVS ☐ Declined

Dating US Details (first US after 7 weeks' gestation; required for EPR/NT referrals for patients living outside Halifax County)
Date of US (yyyy/MON/dd) _____ Gestational age at US _____ weeks _____ days CRL _____ mm

Indication(s) for Referral:

_____
_____
_____
_____
_____
_____
_____
_____

☐ Virtual Image Review (state indication above; images need to be uploaded to PACS if US completed outside NS)
☐ New Brunswick patient requiring ☐ second opinion vs. ☐ relocation for delivery

For FATC Use Only

Date referral received: _____
Date referral triaged: _____

☐ Dating / viability ☐ Cardiac ☐ Transvaginal
☐ Clinic Dopplers ☐ Anatomy ☐ EPR
☐ Multiples ☐ Growth ☐ BPP
☐ Amnio ☐ Growth Plus ☐ FGR
☐ CVS ☐ Virtual Review ☐ Other:

Date of notification: _____
☐ Care provider notified ☐ Patient notified
Method of notification: ☐ Phone ☐ Fax ☐ Other _____

Patient to be seen:
☐ Within _____ days ☐ ASAP
☐ Within _____ wks ☐ At _____ wks = _____
☐ Between _____ and _____

FATC Comments:
☐ FATC not indicated or not possible
_____
_____
_____
_____
_____
_____
_____