IWK Health Centre

Referral for Consult and Ultrasound
Fetal Assessment and Treatment Centre

Phone: (902) 470−6654 Fax: (902) 470−7987

Please Complete All Fields

Patient Name _____ DOB (dd/mm/yyyy) _____

Address _____ HCN _____

_____ Phone Number _____

Referring Physician / Care Provider _____

❑ Gravida ❑ Para ❑ Abortus

LMP (dd/mm/yyyy) _____ Dates certain? ❑ Yes ❑ No

Has an ultrasound been performed in this pregnancy? ❑ Yes ❑ No

If 'Yes':
Date of U/S (dd/mm/yyyy) _____ Gestational Age at U/S _____ weeks _____ days

**** Please attach copy of ultrasound**

Patient Weight _____ BMI _____ Blood Type _____ **** Please attach copy of blood type**

Reason for Referral:

_____

_____

_____

_____

_____

_____

For FATC Use Only

Referral Received _____

Triage Date (dd/mm/yyyy) _____

❑ **Dating / Viability** ❑ **Echo** ❑ **Transvaginal Ultrasound**

❑ **Clinic Dopplers** ❑ **Anatomy** ❑ **Early Pregnancy Review**

❑ **Multiples** ❑ **Growth** ❑ **BPP**

Appointment Date (dd/mm/yyyy) _____ Time (24 hour clock) _____

❑ Physician Notified ❑ Patient Notified

Date of Notification (dd/mm/yyyy) _____

Method of Notification: ❑ Phone ❑ Fax ❑ Other

Patient to be seen: ❑ ASAP

❑ within ____ Days ❑ within ____ Weeks

Patient to be seen at: _____ Weeks

Between _____ (dd/mm/yyyy) and _____ (dd/mm/yyyy)

FATC Physician Comments

_____

_____

_____

_____

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❑ FATC not indicated