Health PEI

Provincial Obstetrical Referral Form

Please identify intended group or recipient prior to sending referral:

Charlottetown (QEH) Obstetrics		
□ **OB Group Charlottetown** The Mount, 143 Mount Edward Rd, 3rd Floor, North Entrance, Charlottetown, PE C1A 5T1	**Office**: 902-629-8801 **Fax:** 902-629-8826 ***Please page the on-call OBS at QEH if immediate consultation required.***	**Please send no later than 28 weeks for expected first visit with OBS at 34 weeks.**
Summerside (PCH) Obstetrics		
OB Group Summerside **Refer to:** □ **Next available appointment** □ Dr. Beth Barbrick-Crozier □ Dr. Hani Farag □ Dr. Brianne Lewis □ Dr. Akin Ojuawo	**Fax**: 902-288-1512 **Email**: summersideobsgynereferrals@ihis.org ***Please page the on-call OBS at PCH if immediate consultation required.***	**Please send referral at any time during pregnancy.**
Summerside (PCH) Family Physicians – Low Risk Obstetrics		
□ **Dr. Heather Austin** 155 Industrial Crescent, Summerside, PE C1N 5N6	**Office***:* 902-724-3425 **Fax:** 833-333-1571 or 902-724-3424	**Please send referral at any time during pregnancy.**
□ **Dr. Erin Dwyer** 155 Industrial Crescent, Summerside, PE C1N 5N6	**Office:** 902-888-3420 **Fax:** 833-693-0569 or 902-724-3424	

Complete in Full:

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 **Other:**	**Interpreter required:** ☐Yes ☐No	**Accessibility Needs:**
Reason for Referral:			

Patient History	
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 ☐

Referring Practitioner	☐ **Unaffiliated Patient**
Name:	**Date of Referral** (*YYYY/MM/DD*)**:**
Phone #:	**Email:**
Name of Primary Care Provider (if not referral source):	**Phone #:**

Referring HCP Signature: _____ **Date (*YYYY/MM/DD*):** _____

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Criteria or Indicators for Early Referral to OBSTETRICIAN

Consider a consultation for <u>pre-pregnancy planning and/or an early referral</u> with individuals with pre-existing conditions requiring treatment prior to pregnancy such as:	Individuals who have experienced any of the following <u>in previous pregnancies</u> may require a referral to OBS:	Individuals with the following conditions **in their current pregnancy** may require a referral to OBS:

• Diabetes – Type I and Type II
• Chronic Hypertension
• Renal disease/failure
• Seizure Disorder treated onanticonvulsant medications
• Significant obesity
• Known parental risk factor for fetal chromosomal abnormality
• Increased risk for fetal abnormality through known family or parental risk factors (i.e. CF, PKD)
 	
• Age ≥40 at EDC (If you are unsure, phone OBS for guidance)
	• Recurrent miscarriage
	• Preterm birth
	• Pre-eclampsia, HELLP syndrome or eclampsia
	• Rhesus isoimmunization or other significant blood group antibodies
	• Gestational diabetes
	• Puerperal psychosis
	• Grand multiparity (given birth more than6 times)
	• A stillbirth or neonatal death
	• A small-for-gestational-age infant (below 10th percentile)
	• A large-for-gestational-age infant (above90th percentile)
	• Prior pregnancy affected with chromosomal, anatomic or syndromic abnormality
	• Uterine surgery (e.g. Caesarean section, myomectomy, cone biopsy, or LEEP)
	• Antenatal or postpartum hemorrhage
	• Other conditions determined by the care provider
		• Cardiac disease including hypertension
		• Renal disease
		• Endocrine disorders or diabetes:
		  ▪ Type I
		  ▪ Type II Diabetes Mellitus, or
		  ▪ A diagnosis of gestational diabetesshould be referred as per CPG
		• Psychiatric disorders (are they wellmanaged; on medication)
		• Hematological disorders
		• Autoimmune disorders
		• Pharmacological therapy (anti-depressants, anti-convulsants, Methadoneetc.)
		• History of infertility of assisted reproductive technology (IVF pregnancy)
		• Multiple gestation
		• Pre-eclampsia
		• Teratogenic risk by infection or class Ddrug
		• Screen positive first trimester MST