

| | | | |
|---------------------------------------|--|---|--|
| Patient Name | | Referring Physician | |
| Address | | Ref. MD Phone # | |
| Phone # | | Ref. MD Fax # | |
| Health Card # | | DOB | |
| Language spoken if other than English | | It is the patient's responsibility to provide interpretation services | |

| | |
|--|------------|
| Obstetrical History: G T P A L EDC: LMP: | |
| Past Medical History: | |
| Risk Factors: | |
| Medications: | Allergies: |

| | | |
|---|-----|----|
| Family Physician Requesting Full Care | YES | NO |
| Family Physician Requesting Shared Care | YES | NO |
| 6 Week Postpartum Check by Referring Family Physician | YES | NO |
| 6 Week Postpartum Check by MC Physician | YES | NO |

APPOINTMENT DATE AND TIME:

IT IS YOUR RESPONSIBILITY TO NOTIFY YOUR PATIENT OF THEIR UPCOMING APPT.
**** All patients will be returned to the care of the referring physician without exception. ****