Rh Prevention Program of Hamilton
Stonechurch Family Health Centre
1475 Upper Ottawa Street
Hamilton, ON L8W 3J6
Phone: (905) 575-0108 Fax: (905) 575-0859

Referral Form: Date of referral: _____/_____/_____
DD / MM / YY

Patient Information:

Name: ____________________
DOB: _______ /______/_____
DD / MM / YY
Address: ____________________
____
Postal Code ____________________
Telephone: (_____)_____________
HNON: ____________________ Version: ______

Family Physician :

Name: ____________________
Address: ____________________
Telephone: ____________________ Fax: _________________

OB-Physician/Midwife providing antenatal care (if different from above):

Name: ____________________
Address: ____________________
Telephone: ____________________ Fax: _________________

Expected Date of Delivery: ______/ _____/ _____
DD / MM / YY

Hospital for Delivery: ____________________

ABO/Rh (please enclose a copy of current pregnancy blood work).
(please ensure service date is on bloodwork). ____(Y) or (N) ____

Please enroll the above-named patient in the Rh Prevention Program of Hamilton:
Please check most appropriate category:

O *Routine 28 week injection of WinRho.*

O Emergency *injection of WinRho following potentially sensitizing event during pregnancy.*
REQUIRES TELEPHONE CONSULTATION .

O Bleed
O Miscarriage
O Medical Abortion

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Name - referring practitioner

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Signature - referring practitioner

You can download copies of this form at: http://www.stonechurchclinic.ca/Services/rh-prevention-program

IMPORTANT NOTICE: The Rh Prevention Program of Hamilton will not enroll a patient without a completed referral form. An appointment time will be confirmed with referring practitioner and patient. Drop-in visits without an arranged appointment will not be accommodated under any circumstances.

Michael G. DeGroote SCHOOL OF MEDICINE

Hamilton Health Sciences