

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. ****