



# OB WHEEL CLINICIANS REFERRAL FORM

For pregnant women **WITHOUT** a family doctor

Please fax to: 613-542-4065

Referrer's Name: \_\_\_\_\_

Referrer's Fax: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT INFORMATION

Last Name:

First Name:

Health Card #: \_\_\_\_\_ (If no health card, advise to contact Midwives)

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

First Day of Last Menstrual Period: \_\_\_\_\_ Due Date (approx): \_\_\_\_\_

Do they have a car or travel by bus? \_\_\_\_\_

## SUPPORTING DETAILS

Please check any of the following that apply to the patient.

Identifies as Indigenous

Previous pregnancies (if so, how many?)  
\_\_\_\_\_

Taking pre-natal vitamins

Previous C-Section

## CLINICAL DETAILS

Has nuchal ultrasound been ordered?

Yes  No

If **No** and they are interested in down syndrome testing, please complete:

Height: \_\_\_\_\_

Diabetes

Weight: \_\_\_\_\_

Smoker

Has prenatal blood work been ordered?

Yes  No

Has the patient had a previous Obs or Family Med Obs provider?

Yes  No

If Yes, who?

Ethnicity: \_\_\_\_\_

\_\_\_\_\_

## DELIVERY DETAILS

Preferred caregiver for the delivery (please check one):

Midwife (fill out online form at ([Kingstonmidwives](http://Kingstonmidwives)))

Family OBS

Obstetrician