IWK Health Centre

Referral for Consult and Ultrasound
Fetal Assessment and Treatment Centre

Phone: (902) 470-6654 Fax: (902) 470-7987

K07002307 Jun/7/2002 M
SCA,TEST Visit
ER0000145/12 **HCN:** 22222222
Van den Hof, TEST / TEST, Maureen
Dec/8/2012

Please Complete All Fields

Patient Name ______________________ DOB (dd/mm/yyyy) ______________

Address ______________________ HCN ______________

______________________ Phone Number ______________

Referring Physician / Care Provider ______________________

☐ Gravida ☐ Para ☐ Abortus

LMP (dd/mm/yyyy) ______________ Dates certain? ☐ Yes ☐ No

Has an ultrasound been performed in this pregnancy? ☐ Yes ☐ No

If 'Yes':
Date of U/S (dd/mm/yyyy) ______________ Gestational Age at U/S ______ weeks ______ days

**** Please attach copy of ultrasound**

Patient Weight ______ BMI ______ Blood Type ______ **** Please attach copy of blood type**

Reason for Referral:

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For FATC Use Only

Referral Received ______________________

Triage Date (dd/mm/yyyy) ______________________

☐ **Dating / Viability** ☐ **Echo** ☐ **Transvaginal Ultrasound**

☐ **Clinic Dopplers** ☐ **Anatomy** ☐ **Early Pregnancy Review**

☐ **Multiples** ☐ **Growth** ☐ **BPP**

Appointment Date (dd/mm/yyyy) ______________ Time (24 hour clock) ______

☐ Physician Notified ☐ Patient Notified

Date of Notification (dd/mm/yyyy) ______________

Method of Notification: ☐ Phone ☐ Fax ☐ Other

Patient to be seen: ☐ ASAP

☐ within ____ Days ☐ within ____ Weeks

Patient to be seen at: ______ Weeks

Between ______________ and ______________
(dd/mm/yyyy) (dd/mm/yyyy)

FATC Physician Comments

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☐ FATC not indicated

ER0000145/12

IWKMAFE