FETAL CARDIOLOGY REFERRAL

Contact booking desk at **905-521-2100 x 78517** for any further questions

Please fax completed forms to:

905-521-5056

Date of Referral: _____

Patient Information

Name: _____

DOB: _____

Health Card #:_____ (OHIP)

Address: _____

City: _____ Postal Code: _____

Telephone: _____ Cellular: _____
Family Physician: _____
Obstetrician: _____
Referring Physician: _____

G: _____

P: _____

A: _____

EDD: _____

GA at time of referral: _____

Twin pregnancy: □ Yes □ No

Interpreter required?
If yes, please specify language: _____

REASON(S) FOR CONSULTATION (*Please select all that apply)*

Fetal:
□ Abnormal cardiac morphology
□ Abnormal cardiac rhythm
□ TTT
□ Other: _____
_____
_____

Maternal/Familial:
□ Mat/Pat/Sibling with cardiac defect
□ Positive Anti-Ro/SSA; Anti-La/SSB
□ Drug/medication exposure: _____
□ Other maternal conditions: _____
□ Other familial conditions: _____
_____

Details of Referral *(frequency of symptoms, other signs and symptoms):*

_____
_____
_____

Medications: _____

Please select and ATTACH all supporting information and results of tests already completed*:*

□ Abnormal obstetric US findings: _____
_____
□ Anti-Ro/SSA; Anti-La/SSB titers: _____
□ Amniocentesis: _____
□ NIPT: _____
□ Other: _____

FETAL CARDIOLOGY OFFICE USE ONLY

Cardiologist's Notes: _____
_____
_____
_____

Triage Dr.: □ ALMEIDA □ DILLENBURG □ MONDAL □ PREDESCU

Received: _____ Triage Date: _____ U#M_____