FMON FAMILY MEDICINE OBSTETRICS NETWORK

P: 204-632-3640
F: 204-231-2214

Date of Referral: _____ Date Received: _____

REFERRING PROVIDER INFO:

Provider Name: _____

Clinic/Hospital: _____

Address: _____

Phone Number: _____

Fax Number: _____

PATIENT INFO:

Patient Name: _____

Date of Birth: _____

PHIN: _____

MHSC: _____

Address: _____

Phone Number: _____

OBSTETRICAL HISTORY:

G: _____ P: _____ SA: _____ TA: _____

LMP: _____ ☐ Unknown

EDD: Day _____ Month _____ Year _____

Previous Caesarian Section: YES ☐ NO ☐

Ultrasound Reports: *See attached:* ☐

1st trimester: YES ☐ NO ☐ Ordered: ☐

20 wk routine: YES ☐ NO ☐ Ordered: ☐

Comment: _____

Relevant Lab Results: _____
See attached: ☐

Medical History: _____
See attached: ☐

Allergies: _____
See attached: ☐

Medications: _____
See attached: ☐

ADDITIONAL INFORMATION:

I will provide care for newborn at 1-2 weeks once discharged from hospital: YES ☐ NO ☐

I will provide care for newborn at 6-8 weeks when mother returns to my care: YES ☐ NO ☐

Please provide a brief summary of the reason for referral and any specific concerns or consideration:

Referring Provider's Signature: _____ Date: _____