MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Family and Newborn Clinic Referral Form

Tel: 416-461-8272 ext. 6690

Instructions for the provider:

- Please submit a separate form if the appointment request is for birthing parent AND baby.
- Please email this completed referral form and relevant labs to FaNClinic@tehn.ca
- If applicable, please send a billing letter (for RMs and CHCs) or UCI# if covered under IFHP.
- A confirmation letter will be faxed back to your office. Please provide the patient with any updated appointment information.
- INCOMPLETE FORMS will not be accepted and risk the patient not being seen promptly

Appointment type
☐ Urgent (next day appointment)
☐ Semi-urgent (within 2-3 days)
☐ Routine (within 1-2 weeks)

***Appointment may change after RM assessment/review of referral**

Appointment request for: ☐ Birthing Parent ☐ Baby	Patient(s) Last Name:	Given Name (s):	Gender at Birth
Preferred Name(s): Pronouns:		Date of Birth: (Day / Month / Year)	
Address: Apt#: Buzzer code:		Phone number:	
Town or City: Province: Postal Code:		Alternate number:	
Ontario Health Card Number: Version Code	Primary Care Provider:	Primary Care Provider Telephone Number:	

INTERPRETER - Is English preferred language? ☐Yes ☐No, the preferred language is:_____
PRIVACY - May we call the patient or leave a message? ☐Yes ☐No
If NO, who can we contact? Name: Tel: Relationship to patient:

Required for Early Discharge Program:
All required discharge papers were given to patient ☐ Yes ☐ No

Required documents include: NBSO/CCHD card, biliary atresia stool chart, discharge summaries and stickers for both parent and infant, a copy of this completed referral form

Reason For Referral:
☐ Bilirubin
☐ BP assessment
☐ Newborn care (with no Primary HCP)
☐ Postpartum follow-up (with no Primary HCP)
☐ Newborn Weight Assessment
☐ RSV immunization
☐ Other _____

Obstetrical history:
G T P A L
Gestational Age: _____
Date and Time of Delivery:_____
Delivery Type:
☐ SVD ☐ Episiotomy ☐ Tear ☐ Degree_____
☐ VBAC
☐ C/S
☐ Assisted delivery (forceps/vacuum)

Blood loss ☐ WNL ☐ PPH _____ mL
☐ Stillbirth follow-up

Serology History:
Hepatitis B ☐ Pos ☐ Neg ☐ Indeterminate
Blood type ☐ A ☐ B ☐ O ☐ AB
Rh ☐ Negative ☐ Positive

GBS ☐ Negative ☐ Positive
GBS treated? ☐ Yes Number of doses _____
☐ No

Prenatal RSV ☐ Yes (date given) _____
☐ No

Newborn History :
Birth weight: ☐ lbs _____ ☐ Kg_____
Discharge weight: ☐ lbs_____ ☐ Kg_____
Weight loss % _____
DAT ☐ Positive ☐ Negative ☐ Unknown

Medications received
☐ Vitamin K ☐ Yes ☐ No
☐ Erythromycin ointment ☐ Yes ☐ No
☐ RSV ☐ Yes ☐ No
☐ Hepatitis B ☐ Yes ☐ No
☐ Other

Feeding:
☐ Breast/Chest Feeding
☐ Formula
☐ Combination

Current issues/Relevant Health Concerns/Conditions (Birthing Parent and/or Baby)

For EMERGENCY DEPT ONLY:
Labs Completed:
☐ CBC
☐ Ultrasound
☐ Blood group and antibody screen
☐ Urine
☐ Other
☐ Not Applicable

Referring Provider: Name**:**

Telephone Number:	Signature:
Billing#:	Fax Number:

Appointment:
☐ Postpartum Clinic Date/Time:_____
☐ Early Discharge Program Date/Time: _____
(Early Discharge Program, to be booked by FBC clerk only)