



Mount Sinai Hospital

Sinai Health System
Joseph & Wolf Lebovic
Health Complex

Frances Bloomberg Centre for Women's and Infants' Health

Women's Unit

700 University Ave., 8th Floor South

Toronto, ON M5G 1Z5

Phone: (416) 586-4800 ext. 4621 Fax: (416) 586-5941

Referral Form

Early Pregnancy Clinic

Complete **ALL** the following information, include requested supporting documentation listed below, and fax to 416-586-5941.

Appointments will **NOT** be given until **ALL** required information is received. Please have your patient contact our office to schedule an appointment at 416-586-4800 x4621 option 1.

Patient Information

Name: _____ Phone: _____
(Last Name) (First Name)

Date of Birth: _____ Health Card No.: _____ VC: _____
(YYYY-MM-DD)

LMP: (date of last menstrual period): _____
(YYYY-MM-DD)

Gravida	Para	Spontaneous Abortion	Therapeutic Abortion	Ectopic
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Does patient need a translator? No Yes If yes, specify language _____

Previously seen in Women's Unit? No Yes If yes, specify year(s) _____

Please check off any that apply:

Vaginal Bleeding Abdominal Pain/Cramping Severe Vomiting

Specific Concerns: (please explain):

To process this referral, the following documentation is required:

Recent Ultrasound Beta hCG result Blood Group & Screen

Referring Physician

Name: _____ Phone: _____
(Last Name) (First Name)

Address: _____ Fax: _____

Email: _____ OHIP Billing No. _____

Early Pregnancy Clinic Use Only

Patient called for appt: No Yes Date of Call: _____ Appt. Date/Time _____

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