Halton Fertility
& WOMEN'S HEALTH CENTRE

EARLY PREGNANCY UNIT REFERRAL FORM
FAX COMPLETED FORM TO:
289 – 891-9591

PATIENT INFORMATION

Apply patient sticker or fill the following:
Last name _____ First name _____
Date of birth (dd/mm/yyyy) _____
Health card number _____
Telephone _____ Alternate number _____

REFERRING PHYSICIAN

Physician Name_____
Telephone _____ Fax _____
OHIP billing number_____ CPSO license number_____

REASON FOR REFERRAL

Gynecology

- ☐ 1st Trimester Vaginal bleeding
- ☐ Pregnancy Localization
- ☐ Suspected Ectopic Pregnancy
- ☐ Failed contraception
- ☐ Abdominal Pain in Pregnancy

Other reason for referral:

_____
_____
_____

Please attach all relevant test results and consultation reports.

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