Alberta Health Services

Patient label placed here *(if applicable)* or if labels are not used, minimum information below is required	
Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	
Gender	PHN
Phone Number	

Obstetrical Outpatient Clinic Referral

Please complete all sections and fax to **780.791.6183**

Type of Referral

☐ Non Stress Test
☐ Obstetrical Consult
Family Practitioner must speak to Obstetrician to consult.
☐ Other *(specify)* _____

Diagnosis

☐ Maternal age 35 or older **OR** 16 or younger
☐ History of stillbirth/recurrent miscarriages
☐ Post dates
☐ Antepartum Hemorrhage (APH) more than 20 weeks
☐ Threatened Preterm Labour (TPTL)
☐ Intrahepatic Cholestasis of Pregnancy (ICP/IHC)
☐ Decreased fetal movement
☐ Decreased/increased amniotic fluid
☐ Gestational hypertension
☐ Twin Pregnancy
☐ Poor reproductive history
☐ Ruptured Membranes
☐ Small/Large gestational age/Intrauterine Growth Restriction (IUGR)
☐ Insulin Dependant Diabetes Mellitus (IDDM)/Diabetes Mellitus predating pregnancy
☐ Gestational diabetes
  ☐ Diet Controlled or
  ☐ Insulin
☐ Other *(specify)* _____

Gravida	Para	Estimated Date of Confinment
Urgency ☐ Urgent *(4 hours)* ☐ Immergent *(24-48 hours)* ☐ Elective *(within 7 days)*	Preferred Date to Book *(yyyy-Mon-dd)* Frequency Requested	

Pre-Existing Medical Conditions

Other Requests/Additional Information

Referring Physician	Date