NorWest Community Health Centres
Centres de santé communautaire NorWest

Midwifery Program Referral Form

CLIENT INFORMATION:

Legal Name: _____ **Preferred Name**: _____

DOB: _____|_____|_____ **Age:** _____ **Phone number**: _____

Year Month Day

Address: _____ **Apt #**:_____**Postal Code**: _____

HC#: _____ **Version code**: _____ ☐ Non-OHIP

Gender: ☐Female ☐ Male ☐ Trans ☐ Other: _____

Preferred pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Unknown ☐Other: _____

REASON FOR REFERRAL

PREGNANCY, SEXUAL & REPRODUCTIVE HEALTH SERVICES:

- ☐ Pregnancy, birth and postpartum care
- ☐ Postnatal & beyond (<2 weeks)
- ☐ Postpartum and newborn care only (>2 weeks)
- ☐ Spontaneous abortion/Missed abortion care
- ☐ Abortion care
- ☐ STI testing
- ☐ Contraceptive counselling (Needs Rx for IUD or Nexplanon)
- ☐ IUD or Nexplanon insertion only (Has Rx)
- ☐ Other: _____

LACTATION SERVICES:

- ☐ Prenatal breastfeeding/chestfeeding education
- ☐ Difficulties latching
- ☐ Breast/Nipple pain
- ☐ Engorgement/Blocked ducts/Mastitis
- ☐ Low milk supply
- ☐ Slow weight gain
- ☐ Multiple gestation
- ☐ Preterm
- ☐ Tongue tie
- ☐ Previous breast surgery
- ☐ Pumping difficulties
- ☐ Other: _____

Please indicate the urgency of your request:

- ☐ SAME DAY/NEXT DAY
- ☐ 1-2 WEEKS
- ☐ NON-URGENT

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MEDICAL HISTORY:

Any significant, ongoing medical issues, unrelated to pregnancy?

Current medications:

Please complete additional information for PREGNANCY-RELATED SERVICES:

Last Menstrual Period: _____ **EDB/Date of Delivery:** _____

Based on: ☐ T1 u/s ☐ T2 u/s ☐ LMP ☐ Conception Date

G ☐ T ☐ P ☐ A ☐ L ☐ # of previous vaginal births: ____ **# of previous caesarean births:** ____

Has this client received prenatal care in this pregnancy? If YES, please circle provider type.

☐ Yes: Midwife, Family MD, OG/GYN, NP **Name:** _____

☐ No ☐ Unknown ☐ Other: _____

Does this client have any significant medical conditions related to the pregnancy (Gestational hypertension, Gestational Diabetes Mellitus, etc.)?

☐ Yes (please specify)_____

☐ No ☐ Unknown

Please complete the following information for NEWBORN CARE SERVICES:

Legal Name: _____ **DOB**: _____

HC#: _____ **Sex:** ☐Female ☐ Male **Birth weight**: _____

REFERRAL INFORMATION:

Name: _____ **Clinic/Agency:** _____

Phone: _____ **Ext:** _____ **Fax:** _____

Please fax referral and any relevant records to (807) 622–3548.
Thank you for your referral.