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

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 _____