



Rosemount Branch  
 30 Rosemount Ave  
 Ottawa, ON K1Y 1P4  
 Tel: 613-688-1177  
 Fax: 613-688-1991

**Referral Form Family Medicine Obstetrics**

*The patient will be contacted directly with appointment date and time.*

**FAX TO 613-688-1991**

Date: \_\_\_\_\_

**Referring Provider Information:**

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

OR OFFICE STAMP

**Patient Information:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 HIN: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Tel: Home: \_\_\_\_\_  
 Cell: \_\_\_\_\_  
 OR AFFIX LABEL

**Referral to:**

- Dr. Elena Charapova
- Dr. Sarah Rice
- Next available physician

**EDD** 20\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Year Month Day

**Would you like us to provide:**

- Complete Prenatal Care?
- Shared Prenatal Care?

**Please provide the following supporting documents (if done):**

- Antenatal 1 and 2                       Ultrasound                       Pap and Swab results
- Blood Work (CBC, TSH, ABO, Rh, antibodies, HBSAg, HIV, Rubella, Syphilis)
- Adacel date given: \_\_\_\_\_  Prenatal Genetic Screening (eFTS/NIPT/MSS)

**\*\*Mom and baby will be returned to you!\*\***

*If you need additional referral forms please go to our website  
[www.swchc.on.ca/our-programs](http://www.swchc.on.ca/our-programs) or visit our website  
[www.mommdoctors.ca](http://www.mommdoctors.ca)*