GRAND RIVER HOSPITAL
Advancing Exceptional Care

Patient Identification Label

OBSTETRIC ROSTER REFERRAL FORM

For expectant patients who need access to an obstetric provider at Grand River Hospital. Form must be completed by an out-of-region provider or provider at a local community health centre.

Please complete the entire form and fax to 519-749-4433.

Roster referrals must be accompanied by:

☐Dating Ultrasound
☐Prenatal bloodwork (eg. BHcG, CBC, blood group & screen etc)

☐URGENT REFERRAL IF GREATER THAN 36 WEEKS GESTATION

PATIENT NAME:	
ADDRESS:	
PHONE:	**ALTERNATE:**
HEALTH NUMBER:	
Last Menstrual Period (LMP):	
REFERRING PROVIDER:	**Billing No.**
Signature:	
Phone:	**Fax:**

The assigned obstetric provider will call patient directly with their appointment time. Please allow 2 weeks for processing.

GRH Clerical Staff Only

Assigned provider: ___________________________

Fax #:______________________________ **Faxed Date:** ______________________

Secretary Initials: _____________________

GRH3459 (REV.06/22)