GRAND RIVER HOSPITAL

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 include:** ☐Dating Ultrasound

**Primary care to initiate:**
☐Prenatal bloodwork (CBC, prenatal group and screen, VDRL, Hep BsAg, HIV and Hep B+C serology)
☐NT/eFTS ultrasound

**Past History of C/Section:** ☐YES ☐NO ☐UNKNOWN
☐**URGENT REFERRAL IF GREATER THAN 36 WEEKS GESTATION**

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|---|---|
| **PATIENT NAME:** | |
| **ADDRESS:** | |
| **PHONE:** | **EMAIL:** |
| **HEALTH NUMBER:** | |
| **REFERRING PROVIDER:** | **Billing No.** |
| **Signature:** | |
| **Phone:** | **Fax:** |

The assigned obstetric provider will call patient directly with their appointment time. Please allow 2-4 weeks for processing.

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|---|---|
| **Patient Accounts Only** FAX: **519-749-4239**<br>**(for Non-Resident/Non-OHIP ONLY)**<br><br>Contact date: _____<br><br>Payment arranged : ☐YES<br><br>Date of CHB notification _____ | **Clerical Staff Only**<br><br>**Assigned provider** _____<br><br>**Fax#**_____<br><br>**Faxed Date:** _____<br><br>**Secretary Initials:** _____ |