SOMERSET WEST COMMUNITY HEALTH CENTRE

Eccles Branch
55 Eccles Street
Ottawa, ON K1R 6S3
Tel: 613-238-1220
Fax: 613-235-2982

Referral Form Family Medicine Obstetrics

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

FAX TO 613-235-2982

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. Megan Williams
- ☐ Next available physician
- ☐ Dr. Dona Bowers
- ☐ Dr. Sarah Rice

EDD 20____/_____/_____
Year Month Day

Would you like us to provide:
- ☐ Complete Prenatal Care?
- ☐ Shared Prenatal Care?

Please provide the following supporting documents:
- ☐ 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 (IPS/FTS/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