



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. Dona Bowers

Dr. Megan Williams

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:

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*