northern health
the northern way of caring

All Sites and Facilities

Maternal Fetal Medicine Clinic Referral

Last Name:
First Name (Preferred Name):
Encounter number: NH Number: Chart Created: Y/N
Date of Birth: Gender: Age: Encounter Type:
Responsibility for Payment: PHN:
Primary Care Physician/Attending Physician:
PATIENT LABEL

University Hospital of Northern BC (UHNBC):
1475 Edmonton Street Prince George, B.C. V2M 1S2
Phone: 250.645.6354 (booking clerk)

Central Intake
Fax all MFM Referrals to Nuclear Medicine:
250.565.5534

Please Complete In Full And Print Clearly

Patient's Full Legal Name: _____ (Last) _____ (First) _____ (Middle)

Other Name(s) (if applicable): _____

Personal Health Number: _____ Date of Birth: ____/____/____ (DD / MM / YYYY) Gender: ☐ M ☐ F

Address: _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Home Phone No: _____ ☐ Okay to Call Message Phone No: _____

Insurance Type: ☐ MSP ☐ WCB ☐ Out-of-Province ☐ Self-Pay Other: _____ RCMP or Armed Forces#: _____

Interpreter Required: ☐ No ☐ Yes Language: _____

Age at referral:	Age at EDC:	
LMP(DD / MM / YYYY): **Regular cycle?**	**Circle which is the final EDC** **EDC by LMP:** (DD / MM / YYYY) **EDC by U/S:** (DD / MM / YYYY)	**Date of earliest ultrasound**(DD / MM / YYYY): **Gestational age at earliest ultrasound**
G **T** **P** **SA** **TA** **L**		**Multiple gestation:** ☐ Yes ☐ No ☐ Twins ☐ Triplets ☐ Other:

Reason for Referral to Maternal Fetal Medicine: (Please see reverse side for critieria details)

- ☐ Pre-pregnancy planning
- ☐ Prenatal consultation (amniocentesis, NT)
- ☐ Maternal medical condition: _____
- ☐ Prior pregnancy concern: _____
- ☐ Present pregnancy concern: _____

Additional Comments:

The Following Records Must Be Received To Process This Referral

- ☐ Antenatal Record Part I and Part II (If started)
- ☐ **Reports of all** ultrasounds done in this pregnancy
- ☐ **All** available lab results: including serum integrated prenatal screen results, blood group and screen, CBC, prenatal screen, PAP smear results, FBS 2 hour OGTT (where indicated), A1C (within 3 months), electrolytes (if applicable, i.e. NVP), vaginal swabs
- ☐ **All** consultation reports and investigational records related to maternal diagnosis

Family Physician (if different from referring source)
Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐ Patient has no GP/NP

Referring Health Care Provider:
Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐ GP ☐ Specialist ☐ NP ☐ Hospitalist ☐ ER ☐ Other

Referring Physician Signature: _____

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PATIENT LABEL	

Criteria

Referrals will be triaged on a priority basis. Criteria include but are not restricted to:

1) Pre-pregnancy planning

2) Prenatal diagnosis Consultation

a) Amniocentesis
b) Soft marker of aneuploidy on detailed ultrasound
c) Maternal serum screen: "SCREEN POSITIVE" after dating ultrasound has been done
d) Patient eligible for extended heart views or screening fetal echocardiogram as per "BCWH guidelines for booking fetal echocardiogram" document

3) Maternal Medical Complications

a) Severe hypertensive disorders ≤ 34 weeks (see SOGC, 2008 definition)
b) Diabetes with maternal end organ disease or fetal complications
c) Significant maternal disease including:
   i. Renal disease ≤ 34 weeks with impaired renal function and/or hypertension
   ii. Cardiac disease at any gestational age
   iii. Gastrointestinal disease unresponsive to treatment ≤ 34 weeks
   iv. History of solid organ transplant at any gestational age
   v. Significant neurological disorder
   vi. Psychiatric disorder requiring hospital admission
   vii. Significant respiratory disorders
   viii. Connective tissue disorders
   ix. Endocrine disorders other than diabetes
   x. Morbid obesity with pre-pregnant BMI ≥ 40
d) Antiphospholipid antibody syndrome ≤ 34 weeks
e) Antenatal infectious disease exposure
f) Rh or other RSC antigen alloimmunization or history of NAIT

4) Obstetrical Complications in Prior Pregnancy – Prenatal diagnosis and care planning with management in conjunction with referring Physician/ Midwife or Obstetrician, as deemed clinically appropriate

a) Previous or current history of shortened/incompetent cervix or significant uterine anomaly
b) PPROM or preterm births ≤ 34 weeks
c) Severe IUGR
d) Second trimester severe hypertensive disorder requiring delivery ≤ 34 weeks
e) Poor perinatal outcome or stillbirth (dependent on etiology)

5) Complications arising in current pregnancy

a) PPROM or preterm labours 34 weeks
b) Any complicated multiple pregnancy (uncomplicated dichorionic twins are currently excluded due to limited resources)
c) Severe IUGR (AC < 5 percentile) or oligohydramnios (DVP < 2cm or AFI 50mm)
d) Anteparturn hemorrhages ≤ 34 weeks with associated PTL or IUGR
e) Fetal arrhythmia at any gestational age
f) Placental concerns

Major fetal anomalies detected ,on ultrasound should be referred directly to Fetal Diagnosis and Therapy Service (FDTS) at BCWH. Phone: 604.875.2848 or 1.888.663.3887 Fax: 604.875.3484.