ROSS MEMORIAL HOSPITAL
Kawartha Lakes

Maternity Group Referral Form

Referring Provider Information:

Name	
Phone	
Fax	
Billing Number	
Date of Referral	

Patient Information:

Name	
Address	
Date of Birth	
Phone Number	
Health Card Number	

EDC: _____ and/or LMP: _____

Patients can be referred at any gestational age.

Obstetrical History:

Past Medical History:

Referring Provider Signature: _____

Please include copies of ALL lab work/investigations/ultrasounds/Ontario Perinatal Records completed during the pregnancy.

Please fax completed form to desired provider:

□	Dr. Lawson:	Fax: 705-320-9115	Phone: 705-320-8874
□	Dr. Mensah:	Fax: 705-320-9906	Phone: 705-320-1977
□	Kawartha Pregnancy & Newborn Care (family physicians)	Fax: 705-328-1816	Phone: 705-324-2561
□	Midwives of Lindsay and the Lakes:	Fax: 705-324-4668	Phone: 705-324-4664