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
- ☐ Family Physicians: Fax: 705-324-1950 Phone: 705-324-9194
- ☐ Midwives of Lindsay and the Lakes: Fax: 705-324-4668 Phone: 705-324-4664