Primary Care Network
ST. ALBERT AND STURGEON
Your PCN. Your Team.
Phone: 780.419.2214

MATERNITY PRIMARY CARE REFERRAL FORM

SUBMIT VIA FAX: 780.419.3482

Date: _____
MM/DD/YYYY

Referring Physician:

Name: _____

Phone: _____

Fax: _____

Address: _____

Required Attachment:

- **Prenatal record and genetic screening results**
- **Out of province/country records**

Please attach patient's label or complete below:

Patient last name: _____

Patient first name: _____

DOB: _____
MM/DD/YYYY

PHN/ULI: _____

Address: _____

Phone # (home): _____

(work): _____ (mobile): _____

Current Obstetric Information - If any of below applies, please refer to OBGYN

☐ Diabetes ☐ Hypertension ☐ Previous C-section ☐ BMI > 40

Relevant History

G: _____ P: _____ A: _____ Gestational age: _____

LMP: _____ EDC: _____
MM/DD/YYYY MM/DD/YYYY

Allergies: _____

Medications: _____

Pre-pregnancy BMI: _____

Other Comments

Request for gender specific primary care physician is not available.