



Referral Form:

Date of referral:

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 DD / MM / YY

**\*\*\*We provide appointment details and reminders to patients that have email and/or cell phone numbers on file.\*\*\***

**Patient has consented to receive email and/or text messages for appointment details/reminders.**

**Patient Information:**

Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
           DD / MM / YY  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Postal Code \_\_\_\_\_  
 Cell Number (\_\_\_\_) \_\_\_\_\_  
 HNON: \_\_\_\_\_ Version: \_\_\_\_\_

**Family Physician:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**OB-Physician/Midwife providing antenatal care (if different from above):**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Expected Date of Delivery:**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 DD / MM / YY

**Hospital for Delivery:** \_\_\_\_\_

ABO/Rh (please enclose a copy of current pregnancy blood work).  
(please ensure service date is on bloodwork).

\_\_\_\_(Y) or (N) \_\_\_\_

**Please enroll the above-named patient in the Rh Prevention Program of Hamilton:**  
**Please check most appropriate category:**

- Routine 28-week injection of WinRho.*
- Emergency injection of WinRho following potentially sensitizing event during pregnancy.*

**REQUIRES TELEPHONE CONSULTATION**

- Bleed
- Miscarriage
- Medical Abortion

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 Name - referring practitioner

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 Signature - referring practitioner

**IMPORTANT NOTICE:** The Rh Prevention Program of Hamilton will not enroll a patient without a completed referral form. An appointment time will be confirmed with referring practitioner and patient. Drop-in visits without an arranged appointment will not be accommodated under any circumstances.

