SAULT AREA HOSPITAL
HÔPITAL DE SAULT-SAINTE-MARIE

iCare

DEMOGRAPHIC LABEL

Sault Area Hospital Prenatal Care Clinic - Referral

Date of Intake: _____

Client Name: _____ Pronouns: _____

Partner's Name: _____

Address: _____ ☐ Rural
(Street) (City) (Postal Code)

Home Phone: _____ Cell#: _____ Work#: _____

D.O.B.: _____ Age: _____ HC# _____ Exp date: _____ Insurer: _____

Weight: _____/_____ Height:_____/_____ BMI: _____ ☐ Smoker
lbs kg ft/in cm

Primary Care Provider: _____

First day of your last menstrual cycle: _____

First Pregnancy: ☐ Yes ☐ No # of children: _____ Year of last birth: _____

Gestation in weeks: _____ Previous Obstetrician: _____

Complications: _____

C Section: _____ Miscarriages: _____ Year: _____

Francophone services? ☐ Yes ☐ No

Notes: _____

Medical Problems: _____

Medications: _____

☐ eFTS TEST ☐ Accepted ☐ Declined Date: _____ Spoke to: _____ ☐ Has been ordered

☐ Panorama Test ☐ Accepted ☐ Declined Date: _____ Spoke to: _____ ☐ Has been ordered

Verbal consent given by client to obtain past Labour and Delivery/Operative Records:

☐ **Accept** ☐ **Decline** ☐ **N/A** **Date:_____**

Date of first appointment: _____ Date of Ultrasound: _____

EDD _____ ☐ 8wk Ultrasound booked Date:_____

Completed by: _____ _____
(Print name) **(Signature)**

Fax Completed Form to 705-256-2580