Markham Stouffville Hospital
Oak Valley Health

York Region

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name: _____ (Last) _____ (First)

Date of Birth: _____ (Day) _____ (Month) _____ (Year) Sex: F M

Health Card # _____ Version Code: _____

Address: _____ Postal Code: _____

☐ WSIB # _____ ☐ Non OHIP (Self-pay) or Refugee

Telephone # (Best Daytime): _____

Alternate #: _____

Family Physician: _____

# Neonatal Follow Up Clinics Referral

Telephone: 905-472-7534

**Please Fax To: 905-472-7535**

☐ **Neurodevelopmental Follow Up with EIS**

☐ **NICU Follow Up**

| **Referral Source/MD** | | | **Referral Phone #** | **Expected Date of Confinement** |
|---|---|---|---|---|
| **CPSO #** | **Billing #** | **Language Preferred** | **Name & number of interpreter to help schedule appointment, if available** | |
| **Parent/Guardian Name** | | | | **Phone #** |
| **Reason for Referral** | | | | |

**Desired Appointment Date:** In _____ weeks / In _____ months **OR** Date: _____

Gestational Age (GA): _____ weeks ☐ AGA ☐ SGA (< 3rd percentile birth weight) ☐ ≥ 1,500 gm ☐ ≤ 1,500 gm

Apgar Scores: _____ 1 min _____ 5 min _____ 10 min ☐ Single ☐ Twin ☐ Triplet ☐ Quad

Birth Weight _____ grams ☐ Syndrome/Disorder: _____

☐ All head ultrasound normal? ☐ Yes ☐ No

☐ Head ultrasounds not done ☐ MRI/CT scan(s): _____

☐ Most recent head ultrasound: _____

☐ Family history of developmental delays, learning disabilities, language disabilities, ADHD, PDD/ASD, hearing impairment

**CENTRAL NERVOUS SYSTEM**

☐ Head circumference < 3%
☐ Periventricular (PV) echoes/flares
☐ Any meningitis except staph epidermidis
☐ Grade I or II IVH, SEH haemorrhage or cysts, Germinal Layer haemorrhage
☐ Hemorrhagic infarct; porencephalic cysts, parenchymal extension
☐ Ventriculomegaly (persistent ventricular dilatation)
☐ Neonatal seizures
☐ Grade III or IV IVH
☐ PVL; porencephaly
☐ Hydrocephalus
☐ Diagnosis of CP
☐ Stroke

**HEMATOLOGIC**

☐ Jaundice / Hyperbilirubinemia (Exchange Level)
☐ Jaundice requiring exchange transfusion
☐ Thrombocytopenia
☐ Anemia requiring transfusion

**CARDIAC**

☐ Patent Ductus Arteriosus (PDA) ☐ CHD
☐ Surgery ☐ No Surgery
☐ Atrial Septal Defect (ASD) ☐ Ventricular Septal Defect (VSD)

**EYES**

☐ Retinopathy of Prematurity (ROP): Stage _____ Zone _____

**GASTROINTESTINAL**

☐ Necrotizing Enterocolitis (NEC)
☐ Surgery ☐ No Surgery

**RESPIRATORY**

☐ Respiratory Distress Syndrome (RDS)/ Hyaline Membrane Disease
☐ Ventilated +/- low flow oxygen less than 36 weeks GA
☐ Persistent Pulmonary Hypertension of the Newborn (PPHN)
☐ Pneumothorax/Pneumothoraces
☐ Severe Bronchopulmonary Dysplasia (BPD) or Chronic Lung Disease (CLD)

**Comments:**

| Name | Signature | Date |
|---|---|---|
| | | |