Newfoundland Labrador

Prenatal Program Referral
Public Health/Community Health

HCN:

Province/Territory: ___ Expiry: YYYY / MON / DD

Name: First Middle Surname

Date of Birth: YYYY / MON / DD Sex: ☐ M ☐ F ☐ UN

Mailing Address:

City: _____ Prov/Terr:_____ Postal Code:_ _ _ _ _ _

Telephone: (Indicate Preferred) ☐ Home (_ _ _) - _ _ _ - _ _ _ _

☐ Cell (_ _ _) -_ _ _-_ _ _ _ ☐ Work (_ _ _) - _ _ _ - _ _ _ _

Ordering Provider's Name_____

Clinic Name: _____

Mailing Address_____

City:_____Prov/Terr:_____ Postal Code: _ _ _ _ _ _

Phone: (_ _ _) -_ _ _- _ _ _ _ Fax: (_ _ _) -_ _ _- _ _ _ _

Ordering Provider's Meditech Mnemonic:_____

Signature:_____Date:YYYY/ MON /DD

Clinic Stamp:(include fax, provider and mnemonics)

EMR Clinic Mnemonic:_____

COPY TO PROVIDER _____

Expected Date of Delivery: Date: YYYY / MON / DD

Please be advised that this client is pregnant and has agreed to be contacted by Public Health/Community Health for:

☐ Prenatal screening and education

☐ Immunization

Public Health/Community Health Contact Information: (Please complete and submit to your appropriate RHA):

☐ **Eastern Health**: Fax :1-709-229-1591

☐ **Central Health:** Fax:1-709-257-3640

☐ **Western Health**: Return to your local Public Health Office

☐ **Labrador-Grenfell Health**: Return to your local Public Health Office

Clear Form Print Form

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