Newfoundland Labrador

PRENATAL REFERRAL FORM TO PUBLIC/COMMUNITY HEALTH

Client Name: _____ DOB: _____
YYYY/MM/DD

HCN:_____ Expiry Date: _____
YYYY/MM/DD

Address: _____

_____

Number(s) where client can be reached:

(__ __ __) __ __ __ – __ __ __ __

(__ __ __) __ __ __ – __ __ __ __

Expected Date of Delivery:

_____
YYYY/MM/DD

Physician Name: _____ Address: _____

_____

Please be advised that this client is pregnant and has agreed to be contacted by public/community health for:

☐ Prenatal screening and education

☐ Immunization

Date: _____
YYYY/MM/DD

Please complete and submit to your appropriate RHA:

- Eastern Health: fax to 1-709-229-1591
- Central Health: fax to 1-709-257-3640
- Western Health: return to your local Public Health Office
- Labrador-Grenfell Health: return to your local Public Health Office