



G.R.O.W. - Referral Form

Please affix patient label(s) here:

Patient e-mail address (required): _____

OHIP Insured: YES NO (private pay) / **OTHER:** _____

Interpreter required: YES NO **Language:** _____

G: ___ **T:** ___ **P:** ___ **A:** ___ **L:** ___ **Gestational age at delivery:** ___ + ___

Date of delivery: _____ **Date of discharge:** _____

Type of delivery: Vaginal C-Section **Complications:** _____

Infant feeding: Exclusive breastfeeding Exclusive formula feeding Combined

Substances used during pregnancy (please circle if any):

Cannabis Amphetamines Opioids Nicotine Alcohol Cocaine Other

Does the patient have a primary care provider? NO YES: _____

Does the patient have a pediatrician for ongoing care? NO YES: _____

Does the patient have a midwife? NO YES: _____

Reason for referral: (please include all concerns that you would like addressed – ex: mental health, social determinants, medical condition, etc...)

Referred by (PRINT): _____ **CPSO#:** _____

SIGNATURE: _____ **OHIP#:** _____

****Referrals without MD/NP information including signature will NOT be accepted****

Please send newborn physical assessment form WITH referral