Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

BLOOD MANAGEMENT SERVICE

Name:_____

PHIN:_____

DOB:_____

HSC MRN#:_____

Request for Consultation/Referral for Obstetrical Patients

Tel: 204-926-8006 Fax: 204-940-3255

Date and Time:

✱Please attach patient's prenatal record if available and most recent blood work

REASON FOR REFERRAL	
☐ Received IV Iron No ☐ Yes ☐ How many doses? _____ Venofer ☐ _____mg Dextran ☐ _____mg	☐Low body weight (<60kg) pre-pregnancy
☐History of anemia Current Hgb:	☐Placenta Abnormalities, specify:
☐Non-consent for transfusion	☐Rare blood type or antibodies
☐Other, specify:	
PATIENT INFORMATION	
Is Patient aware of the referral to BMS? No ☐ Yes ☐	
Patients mailing address:	
City: Province:	Postal Code:
Contact number:	Alternate phone number:
Email address:	
OBSTETRICAL INFORMATION	
EDC:	G: P:
Current Gestation: _____	
Pregnancy complications: No ☐ Yes ☐	
Blood Transfusion History: No ☐ Yes ☐	
Social Services involvement No ☐ Yes ☐	Case Worker: Contact number (if known):
REFERRING HEALTH CARE PROVIDER	
Name:	Designation:
Phone Number:	Fax Number: