# Neonatal Follow Up Clinic – Referral Form

| PATIENT INFORMATION: | | | |
|---|---|---|---|
| Date of Referral: | | | |
| Name: | | | |
| Home Address: | | | |
| Gender: | | Date of Birth: | ____ / ____ / ____<br>DD MM YYYY |
| SH#: | | Gestation: | |
| Health Card # (including version code): | | Preferred Language: | English ○ French ○ |
| Home Phone #: | | Cell Phone #: | |
| Parent/Guardian: | | | |
| Family Physician/NP: | | | |

| REFERRING HEALTH CARE PROVIDER: | |
|---|---|
| Name of referring Health Care Provider: | |

**REASON FOR REFERRAL (must meet criteria):**

| | | | |
|---|---|---|---|
| ☐ Gestation < 32 weeks | ☐ Meningitis/Encephalitis | ☐ Hemolytic disease | ☐ Cleft lip/palate |
| ☐ Birth weight < 1500 g | ☐ Abnormal neuro exam | ☐ Exchange transfusion | ☐ NAS / withdrawal |
| ☐ HIE (Sarnat II or III) | ☐ Hypoglycemia | ☐ Twin transfusion | ☐ Physician discretion |
| ☐ Seizures (newborn) | ☐ Persistent acidemia | ☐ Anemia/cardio instable | |
| ☐ Intracranial bleeding | ☐ PPHN | ☐ Sepsis/cardio instable | |

**ADDITIONAL COMMENTS:**

Please be sure to attach the patient's last dictated clinical note and or any recent lab/imaging results. The patient will be contacted by the Pediatric ACU to have their appointment booked. All required information regarding the NNFU Clinic can be accessed at www.hsnsudbury.ca/NEOKids . Fax form to: **(705) 523-7288** or email form and relevant attachments to neokidsacu@hsnsudbury.ca