MATCH
MIDWIFERY & TORONTO COMMUNITY HEALTH

Provider Referral to MATCH Program

This referral is: ☐**URGENT** ☐**NON-URGENT**

REFERRING PROVIDER INFORMATION:

(Please note we gladly accept referrals from clinical and non-clinical providers. Please complete both pages)

Name:_____Role:_____

Clinic/Agency Name:_____

Address:_____Postal Code:_____

Office Phone:_____ Ext:_____ Office Fax:_____

CLIENT INFORMATION

Legal Name: _____ **Preferred Name:**_____

DOB: _____|_____|_____ **Age:**_____ **Phone number:**_____
Year Month Day

Address:_____ **Apt #:**_____**Postal Code:**_____ ☐ No fixed address

☐ Health Card #_____version code:_____ ☐ IFH#:_____ ☐ No OHIP

Gender: ☐ Female ☐ Male ☐ Trans ☐ Female ☐ Non-binary ☐ Unknown ☐ Other: (specify)_____

Preferred pronouns: ☐She/Her ☐He/Him ☐They/Them ☐Unknown ☐Other: (Specify)_____

Can we leave a message at the phone number provided? ☐ Yes ☐ No

Which type of care are you referring your client to MATCH for:

☐ Pregnancy, birth and postpartum care
☐ Abortion care
☐ Vaccines (clients without OHIP only)
☐ Testosterone injections (with a valid Rx)
☐ Other: _____
☐ Pregnancy options counselling
☐ Pregnancy testing
☐ STI treatment (clients without OHIP only)

MATCH Program
South Riverdale Community Health Centre
955 Queen Street East, Toronto, Ontario
Phone: (416) 461-2493 Fax: (416) 461-8245 match@srchc.com

For pregnancy care referrals please fax any of the following available records:

☐Ontario Perinatal Record
☐Blood group and screen
☐Genetic testing
☐OGCT or OGTT
☐CBC
☐Public health prenatal labs
☐Pregnancy ultrasounds
☐STI testing, urine culture and screening
☐ No records available

For medication abortion referrals please fax any of the following available records:

☐Dating & pregnancy location ultrasound
☐CBC
☐Beta hCG
☐Blood group and screen
☐Chlamydia & gonorrhea
☐ No records available

Estimated date of birth: _____ **Based on:** ☐TI u/s ☐T2 u/s ☐LMP ☐Conception Date

G ☐ **T** ☐ **P** ☐ **A** ☐ **L** ☐

# of previous vaginal births: _____

# of previous caesarean births: _____

Do you have any other relevant information for the midwifery team?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please return this referral and any relevant labs/ultrasounds/pregnancy records by fax to:

(416) 461-8245

The MATCH team reviews all intakes regularly. We usually respond within 24-48 hours.

Please don't hesitate to call our clinic with any questions 416-461-3577 ext #857