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 ☐ 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

Interpretation required? ☐ Yes ☐ No Language:____

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)
- ☐ Early pregnancy loss management with Mifegymiso

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 and early pregnancy loss 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