# Ontario Neonatal Follow-Up Program Referral Form

Birth hospital:
Hospital transferred from:
1st appointment: YYYY/MM/DD
Appointment handout given: Y/N
Follow-up referral made to: see reverse for programs
Shared care eligible: Y/N

| | |
|---|---|
| Current Name: | Age at Birth: _____weeks_____days |
| Birth Surname: | Weight: _____grams |
| Expected Due Date: YYYY/MM/DD | DOB: YYY/MM/DD |
| Date of discharge home: YYY/MM/DD | |
| Parent's (1) Name: | Phone (Home): |
| Address: | Phone (Cell): |
| Parent's (2) Name: | Phone (Home): |
| Address: Same as above Y/N | Phone (Cell): |
| Community primary practitioner: | |

## Criteria for Follow-Up Program

**(as per Neontal Follow-Up Levels of Care, www.pcmch.on.ca)**

| [ ] Regional NICU | [ ] Tertiary Care NICU |
|---|---|
| [ ] Gestational age between 30 0/7 weeks to 33 6/7 weeks | [ ] Gestational age < 30 weeks |
| [ ] BW or HC less than 3rd percentile | [ ] Bronchopulmonary dysplasia (defined as O2 requirement at 36 weeks |
| [ ] Hyperbilirubinemia at exchange transfusion level for gestational age | [ ] HIE Sarnat Level 2 or 3 (moderate or severe encephalopathy |
| [ ] Symptomatic hypoglycemia <2.2mMol over 6h requiring intensive monitoring | [ ] Therapeutic hypothermia |
| [ ] IUD of a twin if surviving twin born <36 6/7 weeks | [ ] IVH >III |
| [ ] Other: | [ ] Meningitis (fungal or bacterial) |
| | [ ] Necrotizing enterocolitis (requiring surgery) |
| | [ ] Neonatal stroke |
| | [ ] Viral encephalitis requiring NICU tertiary care |
| | [ ] Complex congenital anomalies (requiring >2 medical providers) |
| | [ ] Complex surgical cases (requiring >2 providers) |
| | [ ] Other: |

## Criteria for Referral

[ ] NICU discharge summary attached
Referring MD:
Billing number:
Contact information for referring MD: