SURREY MEMORIAL HOSPITAL
MATERNAL PROGRAM
Telephone: 604.585.5638
Facsimile: 604.588.3351

Referral for the Induction of Labour

Patient Name:________________ Contact Telephone:________________

Does Your Patient Require an Interpreter?: Yes ☐ No ☐ Language ____________

PHN:________________ Date of Birth:________________

Most Responsible Physician/Midwife:____________ Date Requested:________

LMP:__________ Date of First U/S:________ Gestational Age at First U/S: ______

EDC (m/y/d):________ Gestation Age:______ weeks G__ T__ P__ A__ L__

INDICATION FOR INDUCTION

☐ **Hypertension in Pregnancy** BP ____ 24-hour Urine Protein ____ Interval growth____N ____↓

U/S Date: ______ Estimated Fetal Weight ______ gms ______ %ile AFI ______

Blood Work: Date: ______AST ____ ALT ____ LD ____ Plt ____ Other ______

☐ **Maternal Medical Condition** *(Specify)* ________________

☐ **Urgent Worsening Condition**

☐ Significant APH ☐ Chorioamnionitis ☐ Suspected Fetal Compromise

☐ **Diabetes** ☐ Gestational (Diet Treated) ☐ Gestational (Insulin Treated) ☐ Pre-gestational

☐ **Reduced Placental Function** *(IUGR and Oligo)*

Interval Growth: ____N ____↓ AFI ______

U/S Estimated Fetal Weight ______ gms ______%ile

☐ **Post-dates** *(Please Send a Copy of the Ultrasounds that Confirm the EDC)*

☐ **PROM** *(Term or Near Term)*

PROM Confirmed by: ☐ Pooling on SSE ☐ Ferning ☐ Oligo on U/S

Group B Strep: ☐ Negative ☐ Positive ☐ Unknown

☐ **Intrauterine Fetal Demise** in This Pregnancy

☐ **Intrauterine Death** in a Prior Pregnancy

☐ **Other** ________________

Name of Consultant (If Applicable): ________________

Physician/Midwife Completing Referral: ________________

Date: ____________