




PRENATAL REFERRAL FORM

PLEASE COMPLETE IN FULL AND PRINT CLEARLY

 **IMPORTANT:** TO ENSURE TIMELY PROCESSING, PLEASE FAX COMPLETED REFERRAL FORM AND ALL AVAILABLE RECORDS (SEE BELOW) TO 250-727-4295

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| 1. ALL obstetrical ultrasound(s) done in this pregnancy | 4. Blood type report from Canadian Blood Services |
| 2. Any prenatal screening results (i.e. SIPS/IPS, NT, etc.) | 5. Hematology panel, any thalassemia investigations |
| 3. Prenatal sheets (Antenatal Record Part 1 & 2) | 6. Any relevant consultations and other reports |

**** The patient and/or referring professional will be notified by the Genetics Clinic of arrangements. ****

PATIENT'S NAME (SURNAME, FIRST, MIDDLE):		OTHER NAME:		DOB: (YY/MM/DD)	DATE OF REFERRAL:
PHN:	MAIDEN NAME:	AGE:	ETHNIC ORIGIN:	MEDICAL GENETICS#:	
ADDRESS:			HOME PHONE #:	CELL PHONE #:	
CITY:	POSTAL CODE:	EMAIL:	ALTERNATE PHONE #:		
PARTNER'S NAME (SURNAME, FIRST):	PHN:	DOB: (YY/MM/DD)	ETHNIC ORIGIN:		

LMP:	BLOOD TYPE:	MULTIPLE GESTATION?: <input type="checkbox"/> YES <input type="checkbox"/> NO	G:	T:	P:	SA:	TA:	L:
DATING SCAN DONE?: <input type="checkbox"/> NO <input type="checkbox"/> YES (COMPLETE BELOW)			DETAILED SCAN DONE / BOOKED?: <input type="checkbox"/> NO <input type="checkbox"/> YES (COMPLETE BELOW)					
DATE: LOCATION:			DATE: LOCATION:					

REASON FOR REFERRAL & RELEVANT CLINICAL/ FAMILY HISTORY:

 **IMPORTANT – PLEASE COMPLETE BELOW:**

Has the patient been informed of the results?	<input type="checkbox"/> YES <input type="checkbox"/> NO → When is disclosure planned?
Prenatal screening (i.e. SIPS/IPS/quad, NT, etc.) done?	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> RESULTS PENDING <input type="checkbox"/> DECLINED
Patient's preference for further testing?	<input type="checkbox"/> AMNIO/CVS <input type="checkbox"/> NIPT <input type="checkbox"/> NO TESTING <input type="checkbox"/> UNDECIDED
Does this patient require an interpreter?	<input type="checkbox"/> NO <input type="checkbox"/> YES → Which language?
Has the family previously been seen in Medical Genetics?	<input type="checkbox"/> NO <input type="checkbox"/> YES → Name of relative, and Program/City where seen?

REFERRING DOCTOR/MIDWIFE:	* PERSON TO CONTACT IN YOUR OFFICE: _____		PHONE #:
MSP BILLING #:	ADDRESS (STREET, CITY, POSTAL CODE):		FAX #:
OTHER DOCTOR:	MSP BILLING #:	PHONE #:	FAX #: