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

1. ALL obstetrical ultrasound(s) done in this pregnancy
2. Any prenatal screening results (i.e. quad screen, NT, etc)
3. Prenatal sheets (Antenatal Record Part 1 & 2)
4. Blood type report from Canadian Blood Services
5. Hematology panel, any thalassemia investigations
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) MRN#:

PHN: MAIDEN NAME: AGE: ETHNIC ORIGIN: MEDICAL GENETICS#:

ADDRESS: HOME PHONE #: WORK PHONE #:

CITY: POSTAL CODE: ALTERNATE PHONE #:

PARTNER’S NAME (SURNAME, FIRST): PHN: DOB: (YY/MM/DD) ETHNIC ORIGIN:

LMP: BLOOD TYPE: MULTIPLE GESTATION?: □ YES □ NO

G: T: P: SA: TA: L:

DATING SCAN DONE?: □ NO □ YES (COMPLETE BELOW) DETAILED SCAN DONE / BOOKED?: □ NO □ YES (COMPLETE BELOW)

DATE: LOCATION: DATE: LOCATION:

REASON FOR REFERRAL & RELEVANT CLINICAL/FAMILY HISTORY:

**IMPORTANT – PLEASE COMPLETE BELOW:**

Does this patient require an interpreter? □ NO □ YES → Which language?

Has the family previously been seen in Medical Genetics? □ NO □ YES → Name of relative, and Program/City where seen?

Prenatal screening (i.e. quad screen, NT, etc) done? □ NO □ YES □ RESULTS PENDING □ DECLINED

REFERRING DOCTOR/MIDWIFE: * PERSON TO CONTACT IN YOUR OFFICE: __________________________ PHONE #:

ADDRESS (STREET, CITY, POSTAL CODE):

MSP BILLING #:

OTHER DOCTOR: MSP BILLING #: PHONE #:

FAX #:

** Please keep photocopied form for future referrals, or find online at http://bcprenatalscreening.ca **  

(August 2009)