London Health Sciences Centre

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Medical Genetics – Prenatal Referral Form

IMPORTANT: TO ENSURE TIMELY PROCESSING, PLEASE FAX COMPLETED REFERRAL FORM AND ALL PRENATAL RECORDS TO (519) 685-8214

1. Blood group and type on a lab report
2. All obstetrical ultrasounds done in this pregnancy
3. Antenatal records (part 1 & 2)
4. Any prenatal screening results (IPS, MSS,FTS etc)
5. Any relevant consultations and other reports

****YOUR OFFICE WILL BE CONTACTED WITH THE APPOINTMENT DATES**

PATIENT NAME: ______________________ DOB (YY/MM/DD) ____________

HEALTH CARD NUMBER______________________ AGE: ____________

ADDRESS______________________ PHONE ____________

______________________ ALT NUMBER____________

______________________ POSTAL CODE____________

REASON FOR REFFERAL

☐ Advanced Maternal Age

☐ Positive Integrated Prenatal Screening

☐ Positive Maternal Serum Screening

☐ Ultrasound abnormality

☐ Other

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Additional relevant clinical and/or family history:

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NEED INTERPRETER ☐ YES ☐ NO LANGUAGE______________________

LMP (YY/MM/DD) ____________ BLOOD GROUP AND TYPE ____________

EDD(YY/MM/DD)____________ GESTATIONAL AGE____________

DATING ULTRASOUND (YY/MM/DD)____________ please send if available

MATERAL SERUM MARKER SCREEN ☐ YES(please send) ☐ NO ☐ DECLINED ☐ PENDING

INTEGRATED PRENATAL SCREENING ☐ YES (please send) ☐ NO ☐ DECLINED ☐ PENDING

Referring Physician ______________________

Address ______________________

____

____

Phone Number ______________________

Fax Number ______________________