

## Medical Genetics – Prenatal Referral Form

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

1. Blood group and type on a lab report **\*must have to book appt\***
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 UMBER \_\_\_\_\_

\_\_\_\_\_ POSTAL CODE \_\_\_\_\_

### REASON FOR REFFERAL

- Advanced Maternal Age
- Positive Integrated Prenatal Screening
- Positive Maternal Serum Screening
- Ultrasound abnormality
- Other

Additional relevant clinical and/or family history

\_\_\_\_\_

\_\_\_\_\_

NEED INTERPRETER  YES  NO LANGUAGE \_\_\_\_\_

LMP (YY/MM/DD) \_\_\_\_\_ DATING ULTRASOUND (YY/MM/DD) \_\_\_\_\_

HAS IPS/MSS BEEN ARRANGED BY YOUR OFFICE?  YES  NO  PATIENT DECLINED  PENDING

HAS THE NUCHAL TRANSLUCENCY ULTRASOUND BEEN SCHEDULE?  YES  NO DATE (YY/MM/DD) \_\_\_\_\_

*Note: \*\*Please forward all pending results when available*

Referring Physician \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_