London Health Sciences Centre

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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 NUMBER**_____

_____ **POSTAL CODE**_____

REASON FOR REFFERAL

☐ **Advanced Maternal Age**

☐ **Positive Integrated Prenatal Screening / Maternal Serum Screening**

☐ **Ultrasound abnormality**

☐ **Other**_____

Additional relevant clinical and/or family history _____

_____

NEED INTERPRETER ☐ YES ☐ NO **LANGUAGE**_____

LMP (YYYY/MM/DD) _____ **DATING ULTRASOUND (YYYY/MM/DD)**_____

HAS IPS/MSS BEEN ARRANGED BY YOUR OFFICE?

☐ **Yes** ☐ **No** ☐ **Patient Declined** ☐ **Pending**

HAS THE NUCHAL TRANSLUCENCY ULTRASOUND BEEN SCHEDULED?

☐ **YES** **DATE: (YYYY/MM/DD)** _____ ☐ **NO**

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

Referring Physician _____

Address _____

_____

Phone Number _____

Fax Number _____