London Health Sciences Centre

Medical Genetics Program of Southwestern Ontario
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Medical Genetics – Prenatal Referral Form

PLEASE FAX COMPLETED REFERRAL FORM AND THE FOLLOWING REQUIRED PRENATAL RECORDS TO 519-685-8214. Missing records may result in a delay of patient's appointment.

- ☐ Blood group and type on a lab report
- ☐ All obstetrical ultrasounds completed in current pregnancy
- ☐ Perinatal Records 1, 2 and 3
- ☐ Any prenatal screening results (eFTS, MSS, NIPT)
- ☐ Any relevant consultations and other reports

******PLEASE ENSURE YOUR PATIENT IS AWARE OF REFERRAL BEFORE SENDING REFERRAL******

YOUR OFFICE WILL BE FAXED A NOTIFICATION WITH THE APPOINTMENT DATE AND TIME, HOWEVER PATIENT MAY BE NOTIFIED OF APPOINTMENT BEFORE YOUR OFFICE IF SCHEDULED URGENTLY

PATIENT NAME: _____ **DOB (MM/DD/YYYY):**_____

HEALTH CARD NUMBER: _____ **AGE:** _____

ADDRESS: _____ **POSTAL CODE:** _____

_____ **PHONE:** _____

EMAIL: _____ **ALT NUMBER:** _____

REASON FOR REFFERAL

☐ **Advanced Maternal Age** (40 years or older at time of delivery)

☐ **Positive eFTS/MSS/NIPT**

☐ **Ultrasound Abnormality**

☐ **Family History of Known Genetic Condition** (Please specify below)

☐ **Other:** _____

Additional relevant clinical and/or family history: _____

_____

INTERPRETER REQUIRED: ☐ YES ☐ NO **LANGUAGE:** _____

LMP (MM/DD/YYYY): _____ **BLOOD GROUP AND TYPE:** _____

EDD (MM/DD/YYYY): _____ **GESTATIONAL AGE:** _____

DATING ULTRASOUND (MM/DD/YYYY): _____ (If not available, please send when available)

HAS eFTS/MSS/NIPT BEEN ARRANGED BY YOUR OFFICE?

☐ **YES** (Please send) ☐ **NO** ☐ **PATIENT DECLINED** ☐ **PENDING** (Please forward when available)

HAS THE NUCHAL TRANSLUCENCY ULTRASOUND BEEN SCHEDULED?

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

Referring Physician: _____

Address: _____

_____

_____

Phone Number: _____

Fax Number: _____

For more information about referral criteria please visit: ***http://www.lhsc.on.ca/Patients_Families_Visitors/Genetics/Prenatal/index.htm*** *Feb 2018*