MEDICAL GENETICS CLINIC PRENATAL REFERRAL FORM

Tel: (604) 875-2818 Fax: (604) 875-3484

Provincial Medical Genetics Program
B.C. Women's Hospital & Health Centre
Room C234, 4500 Oak Street, Vancouver, BC, V6H 3N1

BC WOMEN'S HOSPITAL & HEALTH CENTRE
An Agency of the Provincial Health Services Authority

IMPORTANT: TO ENSURE TIMELY PROCESSING, PLEASE FAX COMPLETED REFERRAL FORM AND ALL PRENATAL RECORDS TO 604-875-3484

1. All obstetrical ultrasound(s) done in this pregnancy
2. Any prenatal screening results (i.e. Quad, SIPS, 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

**** YOUR OFFICE WILL BE CONTACTED WITH THE APPOINTMENTS ****

If you were not contacted with an appointment within 2 days, please call us to confirm if we have rec d your referral

PATIENT'S NAME (SURNAME, FIRST):	DOB (YY/MM/DD):	PHN:	ETHNIC ORIGIN:
ADDRESS:			
HOME PHONE #:	WORK PHONE #:	CELL PHONE #:	
PARTNER'S NAME (SURNAME, FIRST):	DOB (YY/MM/DD):	PHN:	ETHNIC ORIGIN:

LMP DATE:	GRAVIDA:	PARA:	ABORTA:	Has patient been informed of this referral? Ï NO Ï YES
DATING SCAN DONE / PENDING? ☐ NO ☐ YES (COMPLETE BELOW) DATE: LOCATION:				DETAILED SCAN DONE / PENDING? ☐ NO ☐ YES (COMPLETE BELOW) DATE: LOCATION:

REASON FOR REFERRAL:

IMPORTANT ï PLEASE COMPLETE BELOW:

Does this patient require an interpreter? Ï NO Ï YES→ (language)

Family previously assessed in Medical Genetics? Ï NO Ï YES→ (name/DOB)

Prenatal screening (i.e. Quad, SIPS, NT, etc) done? Ï NO Ï DECLINED Ï YES→ last drawn: (date)

REFERRING MD/MIDWIFE:	ADDRESS:	PHONE #:
MSC #:		FAX #:
* PERSON TO CONTACT IN YOUR OFFICE:		*PRIVATE LINE #:
OTHER MD/MIDWIFE:	ADDRESS:	PHONE #:
MSC#:		FAX #: