

# 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



**IMPORTANT: COMPLETE FORM IN FULL & FAX ALL PRENATAL RECORDS TO 604-875-3484**

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| 1. <b>All</b> obstetrical ultrasound(s) done in this pregnancy | 4. Prenatal sheets (Antenatal Record Part 1 & 2) |
| 2. <b>All</b> PN blood work, blood type, CBC, and swabs, etc   | 5. Hemoglobinopathy / thalassemia investigations |
| 3. Prenatal screening report (i.e. Quad, SIPS, NT, etc)        | 6. Any relevant consultations / 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**

REFERRAL DATE:		IS PATIENT AWARE OF THIS REFERRAL? <input type="checkbox"/> NO <input type="checkbox"/> YES	
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:			

REASON FOR REFERRAL:

LMP DATE:	GRAVIDA	PARA	TA	SA	PATIENT'S <u>WEIGHT</u> : KG / LBS	<u>HEIGHT</u> : CM / IN
<u>DATING</u> SCAN DONE / PENDING? <input type="checkbox"/> NO <input type="checkbox"/> YES (COMPLETE BELOW)					<u>DETAILED</u> SCAN DONE / PENDING? <input type="checkbox"/> NO <input type="checkbox"/> YES (COMPLETE BELOW)	
DATE:		LOCATION:			DATE:	
					LOCATION:	
Does this patient require an interpreter? <input type="checkbox"/> NO <input type="checkbox"/> YES→					(language)	
Family previously assessed in Medical Genetics? <input type="checkbox"/> NO <input type="checkbox"/> YES→					(name/DOB)	
Prenatal screening (i.e. Quad, SIPS, NT, etc) done? <input type="checkbox"/> NO <input type="checkbox"/> DECLINED <input type="checkbox"/> 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 #: