BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

Medical Genetics Clinic — Prenatal Referral Form

Main Reception (604) 875-2157
Room C234, 4500 Oak Street
Vancouver, BC, V6H 3N1

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

Date of Referral:

Patient Demographics

Patient Name (Last, First): _____ ** Patient aware of this referral? □Yes □No

DOB: DD_____MM_____YY_____PHN#: _____ Ethnic Origin: _____

Address: _____ Postal Code: _____

Primary Tel: □home □cell □work_____ Alt Tel: □home □cell □work _____

Partner's Name: _____ DOB: DD_____MM_____YY_____PHN#: _____

Interpreter required? □No □Yes ➔ language required:

Pregnancy Details

LMP: DD_____MM_____YY_____Current GA: _____

G_____ P_____ SA _____ TA_____ L

IVF Pregnancy? □No □Yes ➔ was ICSI used? □Yes □No

Patient's Current Weight: _____ □LB □KG

Smoking in pregnancy? □Never □Yes➔current/quit: _____

Diabetes in pregnancy? □No □Type 1 □Type 2 □Gestational

Records Request - check O available reports & fax all records

Antenatal Records □Yes □ No

Blood Type □Yes □ No

Hematology □Yes □ No

Thalassemia □Yes □ No

Virology (rubella) □Yes □ No

Cervical Swabs □Yes □ No

MRSA Positive □Yes □ No

FTS / IPS / SIPS / QUAD } □Yes □No □Declined

NIPT: □Yes □No □Declined

AMNIO: □Yes □No □Declined

Ultrasound: □Yes □No □ Booked

□when & where?

Reason For Referral

□ Genetic counselling to review test results: _____

□ Fetal abnormalities or markers detected on ultrasound: _____

□ Family / Medical / Pregnancy history concerns: _____

□ Other (provide details): _____

Referring Healthcare Provider ➔will be contacted with appt

Name: Billing #:

Address:

Tel:

Private Line: Fax:

Other Healthcare Provider

Name: Billing #:

Address:

Tel:

Private Line: Fax:

****Please call us to follow up if you were not contacted with an appt within 2 days****