

DEPARTMENT OF MEDICAL GENETICS

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

Tel: (604) 875-2818

Fax: (604) 875-3484

PRENATAL REFERRAL FORM

PLEASE COMPLETE IN FULL AND PRINT CLEARLY



IMPORTANT: TO ENSURE TIMELY PROCESSING, PLEASE FAX COMPLETED REFERRAL FORM
AND ALL AVAILABLE RECORDS (SEE BELOW) TO 604-875-3484

1. ALL obstetrical ultrasound(s) done in this pregnancy
2. Any prenatal screening results (i.e. triple screen, 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 ****

PATIENT'S NAME (SURNAME, FIRST):		OTHER NAME:		DOB: (YY/MM/DD)	MEDICAL GENETICS#:
PHN:	MAIDEN NAME:	AGE:	ETHNIC ORIGIN:	BCWH/BCCH#	
ADDRESS:			HOME PHONE #:	WORK PHONE #:	
CITY:			POSTAL CODE:	ALTERNATE PHONE #:	
PARTNER'S NAME (SURNAME, FIRST):		PHN:	DOB: (YY/MM/DD)	ETHNIC ORIGIN:	

LMP:	BLOOD TYPE:	MULTIPLE GESTATION?: <input type="checkbox"/> YES <input type="checkbox"/> NO	G:	T:	P:	SA:	TA:	L:
<u>DATING</u> SCAN DONE?: <input type="checkbox"/> NO <input type="checkbox"/> YES (COMPLETE BELOW) DATE: LOCATION:			<u>DETAILED</u> SCAN DONE / BOOKED?: <input type="checkbox"/> NO <input type="checkbox"/> YES (COMPLETE BELOW) DATE: LOCATION:					

REASON FOR REFERRAL & RELEVANT CLINICAL/ FAMILY HISTORY:



IMPORTANT – PLEASE COMPLETE BELOW:

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

Has the family previously been seen in Medical Genetics? NO YES → (name)

Prenatal screening (i.e. triple marker, NT, etc) done? NO YES RESULTS PENDING DECLINED

REFERRING DOCTOR:	* PERSON TO CONTACT IN YOUR OFFICE: ADDRESS:	PHONE #:
MSP BILLING #:		FAX #:
OTHER DOCTOR:	ADDRESS:	PHONE #:
MSP BILLING #:		FAX #: