BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

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

Prenatal Referral Form

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

If the referral concerns a fetal anomaly detected on ultrasound, go to this site for information regarding the Fetal Diagnosis Service: ➔ http://www.bcwomens.ca/our-services/pregnancy-prenatal-care/complications-in-pregnancy/fetal-diagnosis-service

If the referral is for Maternal Fetal Medicine, please use form:
➔ http://www.bcwomens.ca/our-services/pregnancy-prenatal-care/complications-in-pregnancy/maternal-fetal-medicine

If the patient lives on VANCOUVER ISLAND, refer to:
➔ https://www.islandhealth.ca/sites/default/files/medical-genetics/Documents/Prenetal_referral_form.pdf

By submitting this referral, you are attesting that the patient has been notified.

Patient Demographics *(as appears on BC Care Card)*

Date of Referral:

Patient Name: LAST NAME FIRST NAME PHN: _____

DOB: DD_____ MM _____ YYYY_____ Email Address: _____

Home Address: _____

Primary Tel: _____ Alternative Tel: _____

Partner's Name: LAST NAME FIRST NAME Partner's DOB: DD_____ MM _____ YYYY _____

Ethnic Origin: _____ Partner's Ethnic Origin: _____

Interpreter required? ☐ No Yes➔ ☐ Language required:

Pregnancy Details

EDD: DD MM YYYY Current GA: G: P: SA: TA: L:

Records Request *(Please provide the following records)*

BC Antenatal Record Parts 1 & 2: ☐ Yes Relevant Consult Letters? ☐ No ☐ Yes

NIPS: ☐ Yes ☐ **Declined** FTS / IPS / SIPS / QUAD: ☐ Yes ☐ **Declined**

Ultrasound: ☐ No ☐ Yes ☐ **Booked ➔when and where:** ☐ IVF, PGT, RAD, CMA Reports ☐ **or N/A**

Reason for Referral *(Please include all reports)*

Fetal ultrasound finding. Details: _____

Genetic counselling to review test results. Details:

Concerns Regarding A Family History

Diagnosis in family: _____

How is the affected person(s) related to the referred patient: _____

Clinical question and rationale for consultation: _____

Provide relevant records with a completed Release of Information consent form for affected family member(s):
https://www.bcchildrens.ca/sites/g/files/qpdaav156/files/2025-01/Release%20of%20Information%20Form.pdf

Referring Healthcare Provider:

Name:
MSP Billing #:
Phone:
Private line: Fax:

Other Healthcare Provider/Family Physician:

Name:
MSP Billing #:
Phone: Fax: