



Placental Health Clinic REFERRAL

PHONE: (604) 875-2162 FAX: (604) 875-3255

SURNAME		FIRST NAME	
PERMANENT ADDRESS			
POSTAL CODE	CELL PHONE	HOME PHONE	WORK PHONE
DATE OF BIRTH DD/Mth/YEAR		AGE	
PHN			

Date of referral: ___/___/___
DD / Mth / YEAR

OK for BC Women's Hospital to contact patient? YES NO

Interpreter required Y N (see reverse)

Language: _____

Referring MD/Midwife: _____ MSC Billing #: _____

Phone: _____ FAX: _____

***Indication for referral: (**will be returned if incomplete**)**

G T P E C T S A T A L

EDD ___/___/___
DD / Mth / YEAR

GA: _____
(at date of referral)

****Please complete Risk assessment on reverse****

- Referral for PRISM Ultrasound-based consult
- Referral for PRISM Ultrasound + in person MFM consult
- Referral for Placental pathology review and pregnancy planning
- Other _____

Hospital of Delivery BCW Other

Please attach following documents: Received BCW:

- PRISM Risk Assessment on page 2 of this form
- Antenatal Record 1 & 2
- Bloodwork/Labs
- Consultations
- Ultrasound or Diagnostic Reports
- Pap smear, chlamydia and gonorrhea reports

Referring Office Checklist:

- Care card and Photo ID
- Directions (Entrance #93) – web instructions/map
- Scent Free Clinic

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**Referral for Placental Insufficiency Ultrasound risk assessment (PRISM):
ASA for prevention of pre-eclampsia is recommended as per MFM OBIM Provincial Guideline**

Clinic referral triage based on clinical risk factors and serum analyte profile

- ≥2 moderate risk factors:**
- Nulliparity
 - Maternal age >40
 - BMI >30
 - IVF conception
 - Family history of preeclampsia (1st degree)
 - Previous *term* delivery with preeclampsia*
 - Previous *term* delivery with SGA/ growth restriction*
 - Previous *term* delivery with placental abruption*
 - Smoking >5 cig/ day
 - Pregnancy interval >10 yrs

- ≥1 abnormal maternal serum analyte**
- PAPP-A ≤ 0.15 MoM
 - uE3 ≤ 0.40 MoM
 - AFP 2.5-3.5 MoM
 - hCG 4.0-4.5 MoM
 - Inhibin A 3.0-4.0 MoM

- ≥1 Major risk factor:**
- MAP ≥90 first or second trimester
 - Chronic hypertension
 - Prior preterm delivery due to preeclampsia /FGR/ severe abruption
 - Pre gestational type 1 or 2 diabetes
 - Chronic kidney disease
 - Systemic lupus erythematosus (SLE), antiphospholipid antibody syndrome (APAS), or poorly controlled autoimmune disorders.
 - Previous stillbirth**

- ≥1 severely abnormal maternal serum analyte**
- AFP ≥ 3.5 MoM
 - hCG ≥ 4.5 MoM
 - Inhibin A ≥ 4.0 MoM

Ultrasound-based consultation only:
Send to BCW Ultrasound department: 604-578-3013

- **Ultrasound requisition: for PRISM + anatomical details**
- **Completed Antenatal records part 1 & 2 including BP**
- **Risk stratification form above**

Refer to BCW MFM: 604-875-3255

- MFM PRISM US
- +/- MFM clinic consult (if specifically requested by referring provider).

Refer to BCW MFM: 604-875-3255

- MFM PRISM US
- + MFM consult

*As isolated risk factors, fetal growth assessment is recommended at 32-34 weeks

**where cause of stillbirth is either suspected to be related to placental insufficiency or unexplained

Provincial Language Service Interpretation criteria:

- Patient will be asked to sign **Informed Consent** for treatment/procedure and patient is not fully fluent in English
- Patient has little or no English skills and has no family/friend to translate for them during clinical encounter

Provincial Language Service does not come without significant cost.

If your patient has basic English language skills and can manage her appointment that does not include consent, diagnosis or treatment, please do not request an interpreter.

All information and medical terminology is explained in simple English so the use of an interpreter is not necessary for most appointment types. Should we determine that there is in fact a need, we will access interpretation support via telephone which is an effective modality for interpreting health care as indicated in the most recent literature and current best practices.

Thank you for your cooperation and support.

Diagnostic & Ambulatory Programs
BC Women's Hospital & Health Centre