



**Maternity Ambulatory Program
Prenatal Procedures Unit**

PHONE: (604) 875-2814 FAX: (604) 602-8677

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

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

OK for BC Women's to contact patient? ☐ YES ☐ NO
email: _____

Interpreter required ☐ Y ☐ N (see reverse)
Language: _____

Referring MD/NP/RM: _____ MSP Billing #: _____

Phone: _____ FAX: _____

Copies to: _____ MSP Billing # _____

Copies to: _____ MSP Billing # _____

☒ I have counselled the patient and she would like to proceed with a prenatal procedure. _____ (MD/RM initials)

☐ **C.V.S. (Chorionic Villus Sampling) 11⁰ - 13⁴ weeks gestation**

☐ **Amniocentesis after 15⁴ weeks gestation**

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

☐ Positive prenatal screening/NIPT

☐ Maternal age (egg age) 40 or greater

☐ Previous confirmed Trisomy 13, 18, 21 (funded NIPT declined by patient)

☐ ICSI Pregnancy

☐ Molecular Genetic testing (Medical Genetics referral recommended)

☐ Other: _____

On anticoagulant: ☐ yes ☐ no

Other Rx: _____

G T P ECT SA T A L LNMP ____/____/____
DD / Mth / YEAR

EDD ____/____/____
DD / Mth / YEAR

GA: _____
(at date of referral)

Please provide as much information as possible to allow appropriate triaging to expedite clinical care - the more information the better

Documents to be faxed with this form to complete the referral:

☐ Dating Ultrasound Report

☐ Screening Reports if done (NT, IPS, SIPS, QUAD, NIPT)

☐ Antenatal Record Parts I & II

☐ Completed Prenatal Genetics Lab Requisition

☐ Completed AFP Testing on Amniotic Fluid requisition (if Quad/SIPS/IPS not done)

☐ Blood Type Report (drawn during this pregnancy – if RH negative, must be from Canadian Blood Services, otherwise can be from any North American Lab)

☐ For CVS referral: also send Cervical Swab or urine result for gonorrhea and chlamydia.
(If the test is not completed in advance, the patient will be required to visit the hospital lab to complete the testing prior to their procedure)

Key: (abbreviations): GP = General Practitioner NP = Nurse Practitioner ND = Naturopathic Doctor

EDD = estimated date of delivery (new standard changed from DC) ICSI = Intracytoplasmic sperm injection

CVS = Chorionic Villus sampling LNMP = Last normal menstrual period (new changed from LMP) CRL = crown-rump length

BPD = biparietal diameter RH = Rhesus factor

NT = nuchal translucency IPS = integrated prenatal screening SIPS = serum integrated prenatal screening

QUAD = quadruple marker test NIPT – non-invasive prenatal testing (can you please add this to the list of tests with "screening reports if done")

This form is for the sole use of the intended recipient(s) and contains confidential and privileged information. Any unauthorized use, disclosure or distribution is prohibited. If you are not the intended recipient please contact the sender and destroy all copies.

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.

Maternity Ambulatory Program
BC Women's Hospital & Health Centre

PRENATAL GENETICS LABORATORY REQUISITION

CWGG_REQ_0003 2026/01/01

DIVISION OF GENOME DIAGNOSTICS

at BC Children's & BC Women's Hospitals Facility Code L1050
4500 Oak Street Vancouver, BC V6H 3N1 www.genebc.ca
Molecular Genetics Tel: 604-875-2852, Fax: 604-875-2707
Cytogenetics Tel: 604-875-2304, Fax: 604-875-3601



Patient Education:
BC.mygeneticsadviser.com

*Yellow highlighted fields must be completed.

Bill to → ☐ MSP ☐ PATIENT* ☐ OTHER*: _____ *Billing Form Required (www.genebc.ca)

PERSONAL HEALTH NUMBER		MEDICAL RECORD NUMBER	REFERRING CLINIC ID	If LOCUM above indicate for which PRACTITIONER and include MSP #	
LAST NAME OF PATIENT		FIRST NAME OF PATIENT		Copy to PRACTITIONER/MSP Practitioner Number & Clinic Name/Address	
DOB	YYYY	MMM	DD	Copy to PRACTITIONER/MSP Practitioner Number & Clinic Name/Address	
SEX		MULTIPLE GESTATION – SELECT ONLY ONE			
☐ M ☐ F ☐ X		☐ FETUS A ☐ FETUS B ☐ FETUS C		Copy to PRACTITIONER/MSP Practitioner Number & Clinic Name/Address	
PARTNER NAME (as applicable)		PARTNER PHN (as applicable)			
PREGNANCY INFORMATION				Copy to PRACTITIONER/MSP Practitioner Number & Clinic Name/Address	
GESTATIONAL AGE AT SAMPLE COLLECTION		EDD	YYYY	MMM	DD
weeks days by ☐ U/S ☐ IVF					
FETAL SEX		ASSISTED REPRODUCTION			NON-PRACTITIONER CONTACT (FIRST NAME ONLY), PHONE
☐ M ☐ F ☐ Unknown ☐ Ambiguous		☐ DONOR EGG			
TA PLANNED?		IF YES, RAPID RESULT REQUIRED FOR CLINICAL MANAGEMENT?			
☐ YES		☐ NO ☐ YES (requires Laboratory Geneticist approval)			

REASON FOR TESTING		SAMPLE INFORMATION	
☐ NIPT (attach report) } ☐ T21 ☐ T18 ☐ T13 ☐ Other; specify below		☐ CVS 20 mg ☐ Fetal Blood 2 mL	
☐ IPS/SIPS/Quad/FTS } ☐ Maternal age (as per Perinatal Services BC) ☐ Family History; specify below		☐ Amniotic Fluid 25 mL	
☐ Fetal structural anomaly (specify below) ☐ Other; specify below		☐ Other: _____ Path#: _____	

PRENATAL FETAL GENETIC TEST(S)		
For orders other than RAD & CMA, fax the completed requisition to 604-875-2707 at the time of procedure scheduling		
☐ Prenatal RAD Analysis	Restricted Ordering: ☐ 5-Alpha-Reductase Deficiency Prenatal ☐ AIS Prenatal Test ☐ AS Methylation Prenatal Test ☐ Brugada Syndrome Prenatal Test ☐ CADASIL Prenatal Test ☐ CAPS Prenatal Test ☐ CMT1A Prenatal Test ☐ Dystonia Early Onset Prenatal Test ☐ Familial Mediterranean Fever Prenatal Test ☐ Friedreich Ataxia Prenatal Test ☐ HIDS Prenatal Test ☐ HNPP Prenatal Test ☐ Huntington Disease Prenatal Test ☐ HyperPP Prenatal Test ☐ HypoPP Prenatal Test ☐ Long QT Syndrome Prenatal Test ☐ Muenke Syndrome Prenatal Test	Restricted Ordering: ☐ Myotonic Dystrophy Type 2 Prenatal Test ☐ OPMD Prenatal Test ☐ Prenatal Karyotype Chromosome Analysis ☐ Prenatal Targeted Chromosome Analysis ☐ PWS Methylation Prenatal Test ☐ SBMA Prenatal Test ☐ Sensorineural Hearing Loss Prenatal Test ☐ Spinocerebellar Ataxia Prenatal Panel ☐ Transthyretin Amyloidosis Prenatal Test ☐ TRAPS Prenatal Test ☐ Uniparental Disomy UPD6 Prenatal test ☐ Uniparental Disomy UPD7 Prenatal test ☐ Uniparental Disomy UPD14 Prenatal test ☐ Uniparental Disomy UPD15 Prenatal test ☐ Transfer Sample for 7-dehydrocholesterol

ADDITIONAL CLINICAL FEATURES (CHECK ALL THAT APPLY)		
Abdomen/Chest/Lung/Gastrointestinal ☐ CPAM ☐ Diaphragmatic hernia ☐ Dilated loops / Echogenic bowel ☐ Duodenal atresia / stenosis ☐ Gastroschisis ☐ Meconium peritonitis ☐ Omphalocele Cardiac ☐ Congenital heart defect; specify below Craniofacial ☐ Cleft lip ☐ Cleft palate	Genital/Urinary/Renal; specify anomaly ☐ Genital anomaly ☐ Lower urinary tract anomaly ☐ Renal anomaly Lymphatic/Effusion ☐ Ascites ☐ Cystic hygroma ☐ Edema, subcutaneous ☐ Hydrops ☐ Nuchal translucency increased size (mm): _____ ☐ Pericardial effusion ☐ Pleural effusion	Musculoskeletal ☐ Club foot ☐ Limb anomaly; specify below ☐ Short long bones Neurological ☐ Brain structural anomaly; specify below ☐ Neural tube defect; specify below ☐ Ventriculomegaly Other ☐ Intrauterine growth restriction (IUGR) ☐ Oligohydramnios ☐ Polyhydramnios Specify any other features below

OTHER RELEVANT INFORMATION			
SCHEDULED COLLECTION DATE	COLLECTION SITE	SIGNATURE OF PRACTITIONER	DATE SIGNED

ORDERING PRACTITIONER: ADDRESS, PHONE, MSP PRACTITIONER NUMBER
PRACTITIONERS with multiple clinic sites indicate address results to be sent

DIVISION OF

GENOME

DIAGNOSTICS

USE ONLY

RESET FORM

PRINT FORM