London Health Sciences Centre

Medical Genetics Program of Southwestern Ontario

John McGivney Children's Centre

Tel: 519-252-7281 Ext 350 Fax: 519.977.2216

Medical Genetics – Prenatal Referral Form

*****TO ENSURE TIMELY PROCESSING, PLEASE FAX COMPLETED REFERRAL FORM AND THE FOLLOWING REQUESTED PRENATAL RECORDS TO 519-977-2216*****

1. Blood group and type on a lab report
2. All obstetrical ultrasounds completed in this pregnancy
3. Antenatal Records 1 and 2
4. Any prenatal screening results (IPS, MSS, FTS etc.)
5. Any relevant consultations and other reports

******YOUR OFFICE WILL BE CONTACTED WITH THE APPOINTMENT DATE AND TIME******

PATIENT NAME: _____ **DOB (YYYY/MM/DD):**_____

HEALTH CARD NUMBER: _____ **AGE:** _____

ADDRESS: _____ **POSTAL CODE:** _____

_____ **PHONE:** _____

EMAIL: _____ **ALT NUMBER:** _____

REASON FOR REFFERAL

☐ **Advanced Maternal Age** (40 years or older at time of delivery)

☐ **Positive Integrated Prenatal Screening/Maternal Serum Screening**

☐ **Ultrasound Abnormality**

☐ **Family History of Known Genetic Condition**

☐ **Other:** _____

Additional relevant clinical and/or family history: _____

_____

INTERPRETER REQUIRED: ☐ YES ☐ NO **LANGUAGE:** _____

LMP (YYYY/MM/DD): _____ **BLOOD GROUP AND TYPE:** _____

EDD (YYYY/MM/DD): _____ **GESTATIONAL AGE:** _____

DATING ULTRASOUND (YYYY/MM/DD): _____ (If not available, please send when available)

HAS IPS/MSS BEEN ARRANGED BY YOUR OFFICE?

☐ **YES** (Please send) ☐ **NO** ☐ **PATIENT DECLINED** ☐ **PENDING** (Please forward when available)

HAS THE NUCHAL TRANSLUCENCY ULTRASOUND BEEN SCHEDULED?

☐ **YES** **Date (YYYY/MM/DD):** _____ ☐ **NO**

Referring Physician: _____

Address: _____

_____

Phone Number: _____

Fax Number: _____

For more information about referral criteria please visit: ***http://www.lhsc.on.ca/Patients_Families_Visitors/Genetics/Prenatal/index.htm***