DEPARTMENT OF MEDICAL GENETICS
Victoria General Hospital
1 Hospital Way, Victoria, BC V8Z 6R5

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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 250-727-4295**

1. ALL obstetrical ultrasound(s) done in this pregnancy
2. Any prenatal screening results (i.e. NIPS/SIPS/IPS/Quad Screening/NT)
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

**** The patient and/or referring professional will be notified by the Genetics Clinic of arrangements. ****

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

LMP:	BLOOD TYPE:	MULTIPLE GESTATION?: ☐ YES ☐ NO	G:	T:	P:	SA:	TA:	L:

DATING SCAN DONE?: ☐ NO ☐ YES (COMPLETE BELOW)	DETAILED SCAN DONE / BOOKED?: ☐ NO ☐ YES (COMPLETE BELOW)
DATE: LOCATION:	DATE: LOCATION:

REASON FOR REFERRAL & RELEVANT CLINICAL/ FAMILY HISTORY:

Does this patient require an interpreter? ☐ NO ☐ YES→ Which language?

HAS THIS FAMILY PREVIOUSLY BEEN SEEN IN MEDICAL GENETICS? ☐ No ☐ Yes → Name of Relative, diagnosis and Program/City where seen?

PLEASE SUPPLY NAMES AND BIRTHDATES OF OTHER AFFECTED FAMILY MEMBERS (IF APPLICABLE):

PROVIDE RELEVANT RECORDS WITH A COMPLETED RELEASE OF INFORMATION CONSENT FORM FOR AFFECTED FAMILY MEMBERS. IF A COMPLETE ROI WILL NOT BE ABLE TO BE OBTAINED PLEASE LET OUR OFFICE KNOW.

Prenatal screening (i.e. NIPS/SIPS/IPS/Quad Screening/NT) done? ☐ NO ☐ YES ☐ RESULTS PENDING ☐ DECLINED

REFERRING DOCTOR/MIDWIFE:	*** PERSON TO CONTACT IN YOUR OFFICE:** ________________ ADDRESS (STREET, CITY, POSTAL CODE):		PHONE #:
MSP BILLING #:			FAX #:
OTHER DOCTOR:	MSP BILLING #:	PHONE #:	FAX #: