



Date of Referral:

Patient Demographics

Patient Name (Last, First): _____ ** Patient aware of this referral? Yes No

DOB: DD _____ MM _____ YY _____ PHN#: _____ Ethnic Origin: _____

Address: _____ Postal Code: _____

Primary Tel: home cell work _____ Alt Tel: home cell work _____

Partner's Name: _____ DOB: DD _____ MM _____ YY _____ PHN#: _____

Interpreter required? No Yes → language required:

Pregnancy Details

LMP: DD _____ MM _____ YY _____ Current GA: _____

G _____ P _____ SA _____ TA _____ L _____

IVF Pregnancy? No Yes → was ICSI used? Yes No

Patient's Current Weight: _____ LB KG

Smoking in pregnancy? Never Yes → current/quit: _____

Diabetes in pregnancy? No Type 1 Type 2 Gestational

Records Request - check available reports & fax all records

Antenatal Records Yes No

Blood Type Yes No

Hematology Yes No

Thalassemia Yes No

Virology (rubella) Yes No

Cervical Swabs Yes No

FTS
IPS
SIPS
QUAD } Yes No Declined

NIPT: Yes No Declined

AMNIO: Yes No Declined

Ultrasound: Yes No Booked
↓
← when & where?

Reason For Referral

Genetic counselling to review test results: _____

Fetal abnormalities or markers detected on ultrasound: _____

Family / Medical / Pregnancy history concerns: _____

Other (provide details): _____

Referring Healthcare Provider → will be contacted with appt

Name: _____ Billing #: _____

Address: _____

Tel: _____

Private Line: _____ Fax: _____

Other Healthcare Provider

Name: _____ Billing #: _____

Address: _____

Tel: _____

Private Line: _____ Fax: _____

****Please call us to follow up if you were not contacted with an appt within 2 days****