VANCOUVER ISLAND health authority

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

Tel: (250) 727-4461
Fax: (250) 727-4295

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. quad screen, NT, etc)
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:	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:

IMPORTANT – PLEASE COMPLETE BELOW:

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

Has the family previously been seen in Medical Genetics? ☐ NO ☐ YES→ Name of relative, and Program/City where seen?

Prenatal screening (i.e. quad screen, NT, etc) 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 #:

***** Please keep photocopied form for future referrals, or find online at http://bcprenatalscreening.ca *****

(August 2009)