



**REFERRAL TO THE PRENATAL DIAGNOSIS/
MEDICAL GENETICS PROGRAM**

PATIENT DEMOGRAPHICS:

LAST NAME: _____ FIRST NAME: _____

DOB: YY _____ MM _____ DD _____ OHIP: _____ VC: _____

ADDRESS: _____ POSTAL CODE: _____

HOME TEL: _____ WORK TEL: _____

PREGNANT: YES: LMP: YY _____ MM _____ DD _____ NO:

INVESTIGATIONS/CARE TO DATE:

Antenatal Records Yes No First Trimester Yes No MSS Yes No IPS Yes No

Lab Results Yes No Ultrasound Report(s) Yes No Other Yes No, Specify: _____

PLEASE BE SURE TO ATTACH ALL INVESTIGATIONS/CARE TO DATE WITH THIS REFERRAL

INTERPRETER REQUIRED? YES: NO: LANGUAGE: _____

INDICATE IF ULTRASOUND IS BOOKED BY YOUR OFFICE : YY _____ MM _____ DD _____

REASON FOR REFERRAL:

Late Maternal Age Consult (Maternal age 35 years or older at EDC). Provides information on prenatal diagnosis options e.g. CVS or Amniocentesis. **(Tel: 416-586-5103 Fax: 586-8384)**

Does your patient require NT ultrasound?

No Yes **(Appointments for NT ultrasounds now require a separate CEOU faxed referral form)**

Screen Positive – FTS/IPS/Maternal Serum Screen **(Tel: 416-586-4946 Fax: 416-586-8384)**
(INCLUDE POSITIVE REPORT WITH REFERRAL)

Genetic Counselling – Family history of genetic condition/birth defects **(SPECIFIC DETAILS REQUIRED TO ENSURE APPROPRIATE TRIAGE/GENETIC COUNSELLING)**

Genetic Counselling – Previous child with genetic condition/birth defects **(SPECIFIC DETAILS REQUIRED TO ENSURE APPROPRIATE TRIAGE/GENETIC COUNSELLING)**

Fetal Abnormalities detected on U/S – **FORWARD ALL ULTRASOUNDS PERFORMED**

Other **(Tel: 416-586-4523 Fax: 416-586-4723 – for last 4 requests)**

REFERRING DOCTOR'S INFORMATION: (MUST BE COMPLETED)

DOCTOR'S NAME : _____ / SIGNATURE: _____

TEL: _____ FAX: _____ BILLING #: _____

ADDRESS: _____