MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Frances Bloomberg Centre for Women's & Infants' Health

Prenatal Diagnosis
Medical Genetics Program
Tel: 416-586-4523 Fax: 416-586-4723

Referral

Patient Demographics *(please print)*

Last Name: _____ First Name: _____

DOB: YY_____MM_____ DD _____ OHIP #: _____ VC: _____

Address: _____ Postal Code: _____

Home Tel: _____ Alternate 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 ❑ No ❑ Yes If yes, please specify: _____

Please be sure to ATTACH ALL INVESTIGATIONS/CARE TO DATE WITH THIS REFERRAL

Indicate if ultrasound is booked by your office ❑ No ❑ Yes If yes, specify date booked for _____ *(yy/mm/dd)*

Interpreter Required: ❑ No ❑ Yes If yes, specify language _____

Reason for Referral

❑ **Late Maternal Age Consult** (Maternal age 35 years or older at EDC)
Provides information on prenatal screening and diagnosis options; e.g., CVS or Amniocentesis, IPS/FTS. Please include a copy of dating ultrasound report with referral
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
(include POSITIVE REPORT WITH REFERRAL)

❑ **Genetic Counselling** – Family history of genetic condition/birth defects or 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**
_____

Referring Doctor's Information: (MUST BE COMPLETED)

Doctor's Name: _____ Signature: _____
(please print)

Tel #: _____ Fax: _____ Billing #: _____

Address: _____