Genetics and Metabolism, Shared Health
Health Sciences Centre
Phone: (204) 787-4631
Fax: (204) 787-1419

Date: _____

PRENATAL REFERRAL/FAX SHEET *(updated May 2019)*

PATIENT INFORMATION:

Last Name: _____ First Name: _____

DOB: ____/_____/_____ (dd/mm/yyyy) HSC#: _____

MHSC#:_____ PHIN#:_____

Address: _____ City: _____

Postal code: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

REASON FOR REFERRAL:

1. Positive MSS/NIPT _____
2. Abnormal Ultrasound _____
3. Teratogen Exposure _____
   Medication taken: _____ _____
   Dosage and duration: _____
4. Personal/Family History of: _____ (Please specify disorder/syndrome)

   Name of affected person: _____ *Date of Birth:* _____

   Relationship to referred patient: _____
5. Other: _____

ALL REFERRALS MUST INCLUDE: (incomplete referrals may result in delayed scheduling)

- **Rh report**
- **Prenatal records**
- **All available ultrasound reports**
- **MSS and/or NIPT results (if completed)**

PREGNANCY INFORMATION:

LMP: ___ /____ /_____ (dd/mm/yyyy) Clinical Assessment if Unsure of LMP_____

EDC: ____/_____/_____ (dd/mm/yyyy) U/S Date: _____ Weeks: _____ Other: _____

GRAVIDA _____ PARA_____ SA_____ TA _____

Weight: _____lbs/_____kgs

REFERRING PHYSICIAN :_____*(please print clearly)*

Phone #:_____ Fax #: _____