Genetics and Metabolism
Health Sciences Centre
Phone: (204) 787-4631
Fax: (204) 940-1052

Date: _____

PRENATAL REFERRAL/FAX SHEET *(updated 2024)*

PATIENT INFORMATION:

Last Name: _____ First Name: _____

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

MHSC#:_____ PHIN#:_____

Address: _____ City: _____

Postal code: _____

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

REASON FOR REFERRAL:

☐ Positive MSS
Note: screen positive for open spina bifida to be faxed directly to Fetal Assessment for booking

☐ High risk NIPT

☐ Abnormal Ultrasound

☐ Teratogen Exposure
Medication taken: _____ *Dosage and duration*: _____

☐ Personal/Family History of: _____ (Please specify disorder/syndrome)
Name of affected person: _____ *Date of Birth:* _____
Relationship to referred patient: _____

☐ Other: _____

ALL REFERRALS MUST INCLUDE THE FOLLOWING:
(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) EDC: ____/_____/_____ (dd/mm/yyyy)

U/S Date: _____ Weeks: _____ Other: _____

GRAVIDA _____ PARA_____ SA_____ TA _____

Weight: _____lbs/_____kgs

Interpreter required? □ Yes *Language*: _____
□ No

REFERRING PROVIDER: _____*(please print clearly) *

Phone #: _____ Fax #: _____ Clinic Location : _____