

Your patient will be contacted within **2** business days of receiving the referral. They will receive instructions on booking an appointment by telephone/email/text. If there are any changes to your patient's demographic information, please inform us as soon as possible at: genetics@dynacare.ca.

Referral Date (MM/DD/YYYY): _____

Patients information

	Partner 1	Partner 2 (if necessary)
Patient Name		
DOB (MM/DD/YYYY)		
Biological Sex at Birth (M/F/Other)		
Gender Identity (M/F/Non-Binary/Other)		
Health Card Number		
Address		
Postal Code		
Phone (Mobile preferred) & Email		

Reason for referral

- Advanced Maternal Age
- Positive eFTS /MSS (FTS, SIPS, Quad)/NIPT/NIPS
- Consanguinity
- Teratogen - Medication: _____
- Patient or partner has a known medical condition or birth defect
- Other: _____

Required with EVERY referral

- All obstetrical ultrasound reports in current pregnancy
- Any prenatal screening results

Pregnancy Information

GRAVIDA: _____

PARA: _____

SA: _____

TA: _____

LMP (MM/DD/YYYY): _____

EDD (MM/DD/YYYY): _____

Blood Group and Type: _____

Weight: _____

Obstetric ultrasound (MM/DD/YYYY): _____

*If not available, please send scheduled date of ultrasound)

Has eFTS/MSS/NIPT been arranged by your office?

- Yes No Patient Declined Pending

Has the Nuchal Translucency been scheduled?

- Yes Date: (MM/DD/YYYY): _____
 No

Referring Physician/health care provider:

Genetic counsellor: _____

Address: _____

Phone: _____

Fax: _____

Email address: _____

Billing #: _____