Dynacare®
Genetics and Specialty Services

Dynacare – Preconception Referral Form

Please fax completed form and following required prenatal records to 450-901-3076
Please ensure your patient is aware of referral before sending referral
Missing records may result in delay of patient's appointment

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		

Interpreter required: ☐ Yes ☐ No Language: _____

Referring doctor/health care provider: _____

Clinic information and email: _____

Reason for referral

☐ Patient or partner with previous pregnancy affected by birth defect or other genetic condition

☐ Personal and/or Family History of known condition:

_____

Name of affected person: _____

Relationship to patient: _____

DOB (MM/DD/YYYY): _____

☐ Positive carrier screening for one or both partners (following carrier screening)
Please indicate conditions for each partner:

Partner 1: _____

Partner 2: _____

☐ Consanguinity

☐ Other: _____

Additional relevant clinical and/or family history:

_____