Dynacare®
Genetics and Specialty Services

Dynacare – Prenatal 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		
Email (privacy paragraph)		

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 (eFTS/MSS/NIPT)

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:: _____