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

Date: _____

PRENATAL REFERRAL/FAX SHEET *(updated 2013)*

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Maiden/Previous Name: _____ DOB: ____/_____/_____
(day/ month/ year)

MHSC#:_____ PHIN#:_____

HSC#:_____

Address: _____ Phone Numbers: Home: _____

City: _____ Work: _____ Cell: _____

Postal code: _____ Husband's Name: _____

REASON FOR REFERRAL:

1. Positive Maternal Serum Screen: _____

2. Abnormal Ultrasound: _____

3. Teratogen Exposure: _____

4. Family History of: _____

(Please specify disorder/syndrome)

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

***Relationship to referred patient:* _____**

5. Other: _____

PREGNANCY INFORMATION:

LMP: ___ /____ /_____ Clinical Assessment if Unsure of LMP_____
(day/ month/ year)

EDC: ____/_____/_____ U/S Date:_____ Weeks:_____ Other:_____
(day/ month/ year)

Rh:_____ Ref#: _____ (include faxed copy of report)

GRAVIDA _____ PARA_____ SA_____

Weight: _____lbs/_____kgs Date weight was taken: _____

REFERRING PHYSICIAN:_____*(please print clearly)*

TELEPHONE NUMBER: _____