

ROUTINE PREGNANCY SCREENING REFERRAL FORM

Pregnancy Assessment Clinic (Integrated Prenatal Screening)

Telephone: 905-417-2000 Ext. 5451

Fax: 905-883-2052

Date: _____ (dd/mm/yyyy)

***Referrals will only be processed upon receipt of a completed form. Please ensure to include all supporting documents**

Patient Information

<i>(Print Last, First)</i>		<i>(dd/mm/yyyy)</i>	
Patient Name:		Date of Birth:	
Main Telephone Number:		Alternate Phone Number:	
<i>Street or Apt#</i>		<i>City/Town</i>	<i>Province</i>
Address:		<i>Postal Code</i>	
Health Card Number:		Version Code:	

Referral Physician

<i>(Print Last, First)</i>		Physician Signature:	
Physician Name:		Billing #:	
Telephone Number:		Fax Number:	
<i>Street:</i>	<i>Apt:</i>	<i>City/Town</i>	<i>Province</i>
Address:		<i>Postal Code</i>	

Patient Pregnancy Information

LMP Date: _____ *(dd/mm/yyyy)*

***Please note if LMP unknown please do dating U/S prior to referring patient**

Ultrasound Date: _____ <i>(dd/mm/yyyy)</i>	Ultrasound Crown Rump Length: _____ (mm) Patient Weight: _____ <input type="checkbox"/> Kg <input type="checkbox"/> Lbs
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Multiple Pregnancy: Yes No **If yes, please ensure Ultrasound is sent**

Reason for Referral

Prenatal Screening (Nuchal Translucency Ultrasound, 11-13 + weeks / Maternal Serum Screening)

Fetal Anatomy Ultrasound: (18 – 20 weeks)

***Please be advised if any of the above testing is abnormal or shows evidence of "soft marker" for aneuploidy, automatic referral to Genetics and / or Maternal Fetal Medicine will occur.**

Would you like us to arrange referral to Mackenzie Health Obstetrician? Yes No

Additional Comments:

Supporting Documents Included

Ultrasounds Specialists Reports Antenatal Forms Abnormal Findings Blood Work

First Trimester Screening Integrated Prenatal Screening Maternal Serum Screening Results

PLEASE BE ADVISED: Our clinic will notify your patient of the appointment details, and all reports will be forwarded to your office.

Appropriate follow-up will be arranged when necessary.



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(Feb 2016)

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