Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

KGH Hôpital Général de Kingston General Hospital

DIVISION OF MEDICAL GENETICS
76 Stuart Street, Armstrong 4 South
Kingston, ON K7L 2V7
Telephone: 613-548-2467
Toll free: 1-800-567-5722 ext. 7950
Fax: 613-548-1348

PRENATAL REFERRAL FORM

Please complete all of the following information and fax to: **(613) 548-1348**

Referring Physician / Midwife Information:

Name: ______________________________ OHIP Billing Number: ______________

Address: ____

Phone: (_____)______________________ Fax: (_____)______________________

Patient Information

Name: ______________________________ Phone#: (_______)__________________

Date of Birth: ___________________ (yyyy/mm/dd) HN#: ______________________

Address: ____

____

Last Menstrual Period: _______________ (yyyy/mm/dd) CR# (if available): ________________

Reason for Referral:

To process this referral, the following documentation is required:

- ❑ **Antenatal Records** *
- ❑ **Antenatal blood work** (incl. CBC, type and screen)*
- ❑ **Ultrasound Results** *
- ❑ FTS / IPS / MSS Results (if available for this pregnancy)
- ❑ Other lab tests pertinent for referral
- ❑ Reports of abnormal findings in previous pregnancy or child (e.g. Ultrasound, autopsy, chromosomes)
- ❑ Reports from other specialists involved in this patient's care

*** If referral is for Advanced Maternal Age ONLY, these items are sufficient**

Confidentiality notice: This communication is intended only for the use of the individual or entity to which it is addressed and may contain information which is privileged, confidential, and exempt from disclosure under applicable law. If you are not the intended recipient, and have received this communication in error, please destroy this fax and notify the sender immediately.