Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Queen's University

DIVISION OF MEDICAL GENETICS
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PRENATAL GENETICS - REFERRAL FORM

REFERRING PROVIDER INFORMATION	PATIENT DEMOGRAPHICS
Name_____	Name_____
Phone _____	DOB _____
Fax _____	Phone _____
Signature _____	MOH _____
Date _____	Address _____

Please complete the information below and select the applicable referral criteria

Age at EDD	
EDD	_____ by CRL / LMP (circle one)
GA at referral	_____ weeks _____ days
Please ensure all relevant records are attached	❑ Ontario perinatal record ❑ ABO/Rh blood type ❑ FTS/MSS report ❑ NIPT report ❑ All ultrasound reports (dating, NT, anatomy, follow-up scans)
Referral Indication	❑ Positive FTS/MSS for Down Syndrome (midwife only; physicians can arrange NIPT) ❑ Positive FTS/MSS for Trisomy 18 ❑ High risk, atypical, or "no result" NIPT ❑ Increased NT (3.5mm or greater) ❑ Abnormal fetal ultrasound _____ Has patient been informed of result? Yes _____ No_____ ❑ Family history of genetic condition _____ Side of family affected? Mother of baby _____ Father of baby _____ (Please include genetic test result and relative's relationship to pregnancy) ❑ French Canadian carrier screening (BOTH partners must have first/second degree relative from Saguenay-Lac-St-Jean, Charlevoix, Bas-St-Laurent / Rimouski, Gaspésie, and adjoining New Brunswick) ❑ Ashkenazi Jewish carrier screening (BOTH partners must have ancestry) ❑ Abnormal hemoglobin electrophoresis in patient AND partner (please include Hb electrophoresis, CBC, ferritin, and iron for both individuals) ❑ Other (please specify) _____

We also accept e-consults through OTNHub (https://otnhub.ca/). Please consider sending an e-consult if your referral is regarding management of a diagnosed condition or question of appropriateness of referral. If we have overlooked information, please contact us by phone (613-548-2467) or fax (613-548-1348).