Kingston General Hospital

MEDICAL GENETICS PROGRAM
Armstrong 4, 76 Stuart Street, Kingston ON K7L 2V7
tel: 613-548-2467 fax: 613-548-1348
toll free: 1-800-567-5722 ext. 7950

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**

Updated 2015/09/08