McMaster University Medical Centre

2F Prenatal Diagnosis Clinic

1200 Main St. West, Hamilton ON L8N 3Z5

Genetic Counselling Inquiries **905-521-2100 ext 76247**
Clinic Bookings **905-521-2100 ext 73135**
Fax **905-521-4955**

Physicians	**Genetic Counsellors**
B. DeFrance	G. Cowing
S. McDonald	K. Gardiner
P. Mohide	M. Huggins
M. Morais	N. McNamee
S. Winsor	S. Ruddle
	L. Wallace

Date of Referral: _____

Referring Health Care Provider Information

Name: _____ Provider number: _____

Phone: _____ Fax: _____ Private line: _____

Address: _____ Postal code: _____

Patient Information

Name: _____ Date of Birth: _____

Health card number: _____ Age at EDC: _____

Address: _____ Postal code: _____

Home phone: _____ Alternate phone: _____

LMP: _____ EDC: _____ Gestational age: _____

Does patient need a translator? Yes / No Language: _____

Reason for Referral

☐ **Screen Positive** (please specify and attach report): **FTS / IPS / MSS**

☐ Down syndrome ☐ Trisomy 18 ☐ Neural tube defect (NTD)

☐ **Abnormal ultrasound findings** (please specify and attach report): _____

_____

_____

☐ **Late maternal age** (please specify age at EDC): _____
SOGC clinical practice guideline No. 261 does not recommend amniocentesis or CVS on the basis of maternal age alone. Consider offering FTS / IPS / MSS before referring for amniocentesis or CVS.

☐ **Other** (please specify): _____

_____

_____

All referrals require the following prior to booking:

☐ Ultrasound report confirming a viable pregnancy
☐ Antenatal record 1 and 2

Please also include, if available:

☐ Prenatal bloodwork, including blood group and antibody screen
☐ All ultrasound reports from current pregnancy
☐ FTS, IPS or MSS report
☐ Other related bloodwork, records or results