McMaster University Medical Centre

# Prenatal Diagnosis (PND) Clinic Referral

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**Physicians**

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**Genetic Counsellors**

C. Aziz
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N. Martin-Kenny
N. McNamee
S. Ruddle
L. Wallace

**Date of Referral:** (yyyy/mm/dd) _____

(EDD = Estimated Due Date)

## Referring Health Care Provider Information

Name: _____ Signature: _____ Provider number: _____

Type of provider (Doctor, RM, etc): _____

Phone: _____ Fax: _____ Private line: _____

Address: _____ Postal code: _____

## Patient Information

Name: _____ Date of Birth (yyyy/mm/dd) _____

Health card number: _____ Age at EDD: _____

Address: _____ Postal code: _____

Home phone: _____ Alternate phone: _____

Email address: _____

EDD: (yyyy/mm/dd) _____ Current gestational age: _____

**Does patient need a translator** ☐ **No** ☐ **Yes:** Language: _____

## Reason for Referral

☐ **Screen Positive** (please specify and attach report): **eFTS / MSS / NIPS / NIPT high risk / atypical**

☐ Down syndrome ☐ Trisomy 18 ☐ Other: _____

Risk number / details: _____

☐ **Abnormal ultrasound findings** (please specify findings and any missed views, and attach report):

_____

☐ **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
☐ eFTS / MSS report / NIPS(NIPT) if performed
☐ Other related bloodwork, records or results

***Please note, failure to provide required documentation or a clear indication for referral will lead to delays in triage and may result in the referral being declined***