Maternal genomics

HRN: Site: DOB: yyyy/mon/dd
Last Name: First and Additional Names:
PHN: Gender: Age in Years:
Admitting Physician: Encounter #:
Address: Street, City, Province, Postal Code
Telephone Number:
Date of Admission: yyyy/mon/dd Family Physician:

PHYSICIAN REFERRAL FORM

Please type directly into the form. Where indicated, required referral information may be attached.

Date(yyyy/Mon/dd):	Refer to: **Maternal Genomics**	Fax: +1 (866) 566-7683
Referring Physician:		Phone:
Address:		Fax:
Family Physician:		
Referring Physician Practice ID:	Referring Physician License ID:	

Referral Information

Reason for Referral: **Non-invasive prenatal testing (NIPT)**

Type of referral:
☐New Referral ☐Re-referral ☐2nd Opinion ☐Urgent Referral
☐Service/consultant is aware of urgent referral
Reason for urgency:

Test Indications (choose at least one):
☐Advanced maternal age (≥35 years) ☐Positive serum screen
☐Abnormal ultrasound ☐History suggestive of increased risk for the specified aneuploidies
☐Low risk/maternal anxiety
☐Other:

Past medical history (if relevant) ☐Attached

Current medication/Allergies ☐Attached

Gestational age: Weeks_____ Days_____
As estimated on(yyyy-Mon-dd):

Dating Method: ☐LMP ☐Date of implantation ☐CRL (Please attach ultrasound(s), if applicable.)

☐Other (please specify):

NIPT Selection

NIPT Test Chosen: ☐Singleton Verifi Prenatal Test (chromosomes 21, 18, 13) ☐ Additional option – Sex chromosome aneuploidies (MX, XXX, XXY, and XYY)	☐Verifi Plus Prenatal Test (chromosomes 21, 18, 13) (Singleton only) ☐ Additional option – Microdeletions (1p36 deletion, 4p- (Wolf-Hirschhorn syndrome), 5p- (cri-du-chat syndrome), 15q11.2 (Prader-Willi syndrome/Angelman syndrome), 22q11. Deletion (DiGeorge syndrome) ☐ Additional option – Sex chromosome aneuploidies (MX, XXX, XXY, and XYY) ☐ Additional option – All chromosome aneuploidies (MX, XXX, XXY, and XYY)
☐Twin Verifi Prenatal Test (chromosomes 21, 18, 13) ☐ Additional option – Presence of Y chromosome	
Factors that may affect consultation/care	☐Language: ☐Interpreter needed ☐Physical limitations ☐Social/psychological ☐Specific patient request:

Maternal Genomics use only

Referral received by:	Signature:
Received date[yyyy-Mon-dd]:	