



If the referral concerns a fetal anomaly detected on ultrasound, go to this site for information regarding the Fetal Diagnosis Service:
→ <http://www.bcwomens.ca/health-professionals/refer-a-patient/fetal-diagnosis-service>

If the referral is for Maternal Fetal Medicine, please use form:
→ <http://www.bcwomens.ca/health-professionals/refer-a-patient/maternal-fetal-medicine-clinic>

If the patient lives on VANCOUVER ISLAND, refer to:
→ https://www.islandhealth.ca/sites/default/files/2019-02/Prenatal_referral_form.pdf

By submitting this referral, you are attesting that the patient has been notified.

Patient Demographics (as appears on BC Care Card)

Date of Referral: _____

Patient Name: _____	LAST NAME	FIRST NAME	PHN: _____
DOB: DD _____ MM _____ YYYY _____	Email Address: _____		
Home Address: _____			
Primary Tel: _____		Alternative Tel: _____	
Partner's Name: _____	LAST NAME	FIRST NAME	Partner's DOB: DD _____ MM _____ YYYY _____
Ethnic Origin: _____		Partner's Ethnic Origin: _____	
Interpreter required? <input type="checkbox"/> No		Yes → <input type="checkbox"/> Language required:	

Pregnancy Details

EDD: DD _____ MM _____ YYYY _____	Current GA: _____	G: _____	P: _____	SA: _____	TA: _____	L: _____
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Records Request (Please provide the following records)

BC Antenatal Record Parts 1 & 2: <input type="checkbox"/> Yes	Relevant Consult Letters? <input type="checkbox"/> No <input type="checkbox"/> Yes
NIPS: <input type="checkbox"/> Yes <input type="checkbox"/> Declined	FTS / IPS / SIPS / QUAD: <input type="checkbox"/> Yes <input type="checkbox"/> Declined
Ultrasound: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Booked → when and where: _____	<input type="checkbox"/> IVF, PGT, RAD, CMA Reports <input type="checkbox"/> or N/A

Reason for Referral (Please include all reports)

Fetal ultrasound finding. Details: _____
Genetic counselling to review test results. Details: _____

Concerns Regarding A Family History

Diagnosis in family: _____
How is the affected person(s) related to the referred patient: _____
Clinical question and rationale for consultation: _____

Provide relevant records with a completed Release of Information consent form for affected family member(s):
<http://www.bcchildrens.ca/your-visit-site/Documents/Release%20Information%20Form.pdf>

Referring Healthcare Provider:

Name: _____
MSP Billing #: _____
Phone: _____
Private line: _____ Fax: _____

Other Healthcare Provider/Family Physician:

Name: _____
MSP Billing #: _____
Phone: _____ Fax: _____