FETAL DIAGNOSIS SERVICE (FDS) CLINIC
Tel: 604-875-2848 Fax: 604-875-3484

BC WOMEN'S HOSPITAL & HEALTH CENTRE
An Agency of the Provincial Health Services Authority

Medical Genetics, Maternal Fetal Medicine, Diagnostic Ambulatory Program

IMPORTANT: TO ENSURE TIMELY PROCESSING, PLEASE FAX COMPLETED REFERRAL FORM AND ALL PRENATAL RECORDS TO 604-875-3484

1. All obstetrical ultrasounds done in this pregnancy
2. Any prenatal screening results (i.e. Quad, SIPS, NT, etc)
3. Prenatal sheets (Antenatal Record Part 1 & 2)
4. Blood type report from Canadian Blood Services
5. Hematology panel, any thalassemia investigations
6. All prenatal blood work

**** YOUR OFFICE WILL BE CONTACTED WITH THE APPOINTMENTS ****

Date of Referral: _____
(Day) (Month) (Year)

Patient's name: _____
SURNAME GIVEN NAME

Birthdate: _____ PHN: _____ LMP: _____
(Day) (Month) (Year) (Day) (Month) (Year)

Address: _____

Home Telephone: _____ Work #: _____ Cell#: _____

Interpreter required? NO / YES: _____ Language: _____

Reason for referral:

_____

_____

Has patient been informed of this referral? NO / YES

Referring physician:

MD/midwife name: _____ MSC#: _____
Address: _____
_____
Telephone: _____ Fax #: _____
Person to contact in your office: _____ private line: _____

Other MD/midwife: _____ MSC#: _____
Address: _____
_____
Telephone: _____ Fax #: _____

BCWH USE ONLY:

MRUN_____
MG# _____

Appt date:_____
History @ _____
U/S @ _____
Echo @ _____
MG @ _____
MFM @ _____