GENETICS CENTER

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Prenatal Patient Referral

Patient Information:

Name:_____ DOB: _____ English/Spanish (circle one)

Address:_____

Home Phone:_____ Work/Cell Phone:_____

Medical Information:

Referral Reason:_____

Referring Doctor:_____ Location:_____

LMP:_____ EDC:_____ CA Prenatal Screening Program Form #:_____

Previous Ultrasound With This Pregnancy? □ Yes □ No Date Performed:_____; ____wks ____days

Has this patient had non-invasive prenatal testing/NIPT? □ Yes □ No Date Performed:_____

Gravida:_____ Para:_____ SAB:_____ Blood Type:_____ MCV:_____

Insurance:

Healthplan:_____ Medical Grp/IPA:_____ ID#:_____

Requested Services:

□ Genetic Consult & Indicated Testing □ CA Prenatal Screening Program and/or Nuchal Translucency (NT) measurement

□ High Resolution Ultrasound □ Fetal Echo □ Chorionic Villus Sampling (CVS) □ Amniocentesis

Lab: □ Cystic Fibrosis (CF) □ Fragile X □ Spinal Muscular Atrophy Carrier Screening
□ Blood Chromosome Analysis □ Thrombotic Risk Panel □ Other:_____

Physician Signature:_____

PLEASE FAX BLOOD TYPE, CBC REPORT & ANY PRIOR ULTRASOUND REPORTS
Fax #: 714-288-3510