



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 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

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