Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

Prenatal Diagnosis and Medical Genetics Program
Ontario Power Generation (OPG) Bldg., 3rd floor
700 University Ave., Toronto, ON M5G 1Z5
Tel: 416-586-4523 **Fax: 416-586-4723**

Referral Form

Patient Demographics *(please print)*

Last Name: _____ First Name: _____

DOB: _____ OHIP #: _____ VC: _____
(yyyy-mm-dd)

Address: _____ Postal Code: _____

Home Tel: _____ Work Tel: _____ Cell No. _____

PREGNANT: ❑ No ❑ Yes **LMP**: _____
(yyyy-mm-dd)

Interpreter Required? ❑ No ❑ Yes If yes, specify **LANGUAGE:** _____

Please be sure to ATTACH ALL INVESTIGATIONS / CARE TO-DATE WITH THIS REFERRAL to ensure efficient processing of referral.

Check reason for referral:

❑ **Prenatal Invasive Procedure: Chorionic Villi Sampling or Amniocentesis**
Required documents to be sent with referral: Blood group and type, dating ultrasound and all requisitions etc.
Previous Genetic Consultation: ❑ No ❑ Yes If yes, specify: _____

❑ **Screen Positive** – FTS / IPS / NIPT / MSS
Required documents to be sent with referral: Blood group and type, screening report(s), ultrasound(s), antenatals
NIPT Initiated: ❑ No ❑ Yes If yes, specify date: _____
(yyyy-mm-dd)

❑ **Fetal Abnormalities/Soft Markers detected on Ultrasound**
Required documents to be sent with referral: Blood group and type, screening report(s), ultrasound(s), antenatals
_____
_____

❑ **Genetic Counselling: Family history of/previous child with genetic condition/birth defects**
Required documents to be sent with referral: ALL documentation available regarding the reason for referral
_____
_____

❑ **Other** (please specify)_____
_____

Referring Doctor's Information

Doctor's Name: _____ Signature: _____
(please print)

Tel: _____ FAX: _____ Billing # _____

Address: _____
_____