GENETICS CENTER

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Prenatal Patient Referral

Referral Reason & Physician Signature Must Be Included

Patient Information:

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

Address:_____

Home Phone:_____ Work/Cell Phone:_____

Medical Information:

Referral Reason: ☐ Advanced Maternal Age ☐ Family History of_____
(Required) ☐ Abnormal State Screening ☐ Abnormal Ultrasound ☐ Multiple Miscarriages
☐ Other:_____

Referring Doctor:_____ Location:_____

Has this patient had Cell-free DNA (cfDNA)/NIPT Testing? ☐ Yes ☐ No Date Performed:_____

CA Prenatal Screening Program Form #:_____
(Must be provide if applicable)

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

LMP:_____ EDC:_____ Blood Type:_____ MCV:_____

Insurance:

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

Requested Services:

☐ Genetic Consult & Indicated Testing as a result of Genetic Consult

Lab: ☐ Cystic Fibrosis (CF) ☐ Fragile X ☐ Spinal Muscular Atrophy Carrier Screening
☐ Blood Chromosome Analysis ☐ Other:_____

Physician Signature:_____
(Required)

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