PRENATAL GENETICS LA				Dationt Inf	armation				
BC Children's Hospital and BC Women's Hospital Facility Code L1050				Patient Information Last Name First and Middle Names					
4500 Oak Street, Vancouver B.C. V6H 3N1 Cytogenetics Tel: 604-875-2304, Fax: 604-875-3601 Molecular Genetics Tel: 604-875-2852, Fax: 604-875-2707									
							Date of Birth (DD/I	MMM/YY)	
www.genebc.ca					X Female				
Ordering Physician Last Name	Billing #		Personal Health Number (PHN)		Referring Hospital ID Referring Clinic ID				
_ast Name First Name			Address						
Address				Address					
Address				Patient Phone	Number		Multiple Gestation –	select only ONF:	
Phone Fax									
							Fetus A Fetus B Fetus C		
Contact Person / Genetic Counsellor									
Copy Physician		Billing #		GENETICS LABORATORY				TORY	
				LABE			LS ONLY		
Copy Physician		Billing #							
Reproductive History		Procedure Date (DD/MMM/		Current Ge	stational Age		☐ EDD by U/S	□ LMP (DD/MMM/YY)	
G: T: P: A: L:				weeks days		ays			
Reason For Referral REQUIRED									
□ 10+ vears	Choose all that	t apply; analysi	s will not be perfori	med unless a _l	ppropriate history	is provid	led.		
 40+ years 35 – 39 years, no prior screening, singleton, ≥ 21 wks gestation (at first prenatal visit) Age at projected birth:									
□ ≥35 years, no prior screening, multiple destation									
Positive maternal screen: IPS SIPS Quad NIPT Other: Positive for: T18 Risk:									
In vitro fertilization with intracytoplasmic sperm injection (IVF with ICSI)									
		•	,						
Additional information must be provided for the following: Relevant clinical and family history:									
☐ Fetal ultrasound abnormality									
☐ Fetus at risk of inherited disease									
☐ Personal/family history of chromosome abnormality									
☐ Follow up after CVS									
☐ Culture for: ☐ Biochemical Genetics ☐ Possible future testing (please specify)									
☐ Supernatant fluid to: ☐ Bioche	emical Genetics	☐ Clinical Bi	ochemistry						
Test(s) Requested				Sample 1	Type Use this r	requisition	for prenatal sample	es ONLY	
☐ QF-PCR Rapid Aneuploidy Detection (RAD)				□ 25 mL A	Amniotic fluid	□ 2 r	mL Fetal Blood	(Kleihauer required for cordocentesis)	
☐ Chromosome microarray (CMA)				☐ 20 mg CVS ☐ Other: Path #					
Molecular test:					on Details		HCI	raur#	
Specify test & FA	X req to MGL (27	707) at time of	scheduling		(DD/MMM/YY)		Time Collected (HF	H:MM)	
Other:									
Specify (ex. Karyotype, FISH probe)									
0.1 : 51 :: 0:		<u> </u>							
Ordering Physician Signature REQUIF	KED	Date							
Date Arrived: F	Previous Studies:								
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GENETICS LABORATORY USE ONLY									