Genetic Counseling/Prenatal Diagnosis
REFERRAL FORM

Office Use
GC: ______ MD: ______
Date: ______
Couns: ______
U/S: ______
Amnio: ______

Prenatal Genetics and Fetal Therapy Program
University of Washington Medical Center
Department of Obstetrics and Gynecology
Box 356460
Seattle, WA 98195-6460

Phone: (206) 598-8130
Fax: (206) 598-2359

Today's Date ______

PATIENT INFORMATION

Patient Name ______ EDC ______ ☐ by LMP ☐ by U/S

LMP ______ Date of **First** U/S ______ Gest. Age at **First** U/S ______

Patient Age at Delivery ______ Parity ______ Blood Type ______

SS# ______ DOB ______

Home Phone ______ Work Phone ______

Address ______

City ______ State ______ Zip ______

Partner's Name ______ ☐ Married ☐ Single

Insurance ______ Group Health # *(if applicable)* ______

Reason(s) for Referral:
- ☐ Age 35 or older
- ☐ Positive serum screen for:
  - ☐ Down Syndrome
  - ☐ Trisomy 18
  - ☐ NTD
- ☐ Abnormal ultrasound *(describe:* ______ *)*
- ☐ Family history genetic disease/birth defect *(indicate condition on line below)*

  ______
- ☐ Other ______

Special Instructions ______

REFERRAL INFORMATION

Referring MD *(Facility)* ______ UPIN # ______

Address ______

City ______ State ______ Zip ______

Backline Phone ______ FAX ______

Delivery Hospital ______

PATIENT REFERRAL CHECKLIST

Be sure to fax the following, along with this completed form, to **(206) 598-2359**:

- ☐ Blood type report
- ☐ All ultrasound reports from current pregnancy
- ☐ Serum screening report
- ☐ Pertinent prenatal records
- ☐ Medical records of affected individual(s) for family history genetic disease/birth defects
- ☐ Insurance preauthorization, if applicable