To: **Genetic Counseling**, OBGYN at Boston Medical Center

Fax: 617-638-6756

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Name DOB Social Security # Phone #

Interpreter Need? Yes No Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Carrier Policy Number

|  |
| --- |
| **Genetic Counseling** |
| Indication for exam/Reason for referral:   |  |  | | --- | --- | | * Advanced maternal age | * Other genetic disease carrier | | * Consanguinity | * Personal history of genetic condition | | * Cystic fibrosis carrier\*\* | * Positive maternal serum screening | | * Discussion of genetic testing options, expanded carrier screening | * Preconception consultation | | * Family history of birth defects | * Recent pregnancy loss, discuss testing | | * Family history of genetic condition | * Recurrent pregnancy loss | | * Family history of intellectual disabilities | * Spinal muscular atrophy carrier \*\* | | * Hemoglobinopathy carrier\*\* * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * Ultrasound abnormality | | \*\* Has patient's reproductive partner received testing? Yes\_\_\_\_\_\_\_\_No\_\_\_\_\_\_Unknown\_\_\_\_\_\_\_ | | |

PREGNANCY INFORMATION:

LMP \_\_\_/\_\_\_/\_\_\_ EDC \_\_\_/\_\_\_/\_\_\_ if by ultrasound: date: \_\_\_/\_\_\_/\_\_\_ GA at ultrasound \_\_\_ wks\_\_\_days G\_\_\_\_\_\_\_P\_\_\_\_\_\_\_

THIS PREGNANCY COMPLICATED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS PREGNANCY COMPLICATED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*Has the patient been seen at BMC for this pregnancy before? (please circle)*** **YES NO**

**INCLUDED WITH THIS FORM, PLEASE FAX ALL RELEVANT MEDICAL RECORDS**

\*PLEASE NOTE- Separate referrals must be submitted for obstetrics, antenatal testing unit and genetic counseling respectively\*