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

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| --- |
| **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\*