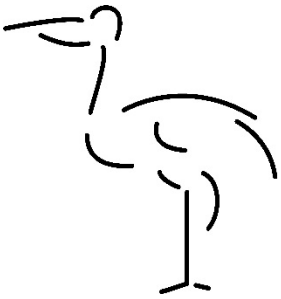

Lions Gate Maternity Clinic

Lions Gate Hospital
Room 302, 3rd Floor
231 15th Street East
North Vancouver BC V7L 2L7

Phone: 604-985-6408
Fax: 604-985-6108
Website: www.lgmc.ca
lghmatclinic@gmail.com

Date of Referral: _____

FAX all relevant information including obstetrical ultrasounds, prenatal bloodwork, most recent pap test with the complete referral, **including Antenatal Records if started**. We usually see patients when they are 9-10 weeks gestational age. **Please order their dating ultrasound for 8 weeks estimated GA and copy us to the report.**

Last Name: _____ First Name: _____
Address: _____ DOB (YYYY/MM/DD): _____
_____ PHN #: _____
Contact Number(s): _____
Other Contact Name and Number(s): _____

Referring source: □ Family Physician □ Obstetrician □ Midwife
_____ Billing Number #: _____
Phone: _____ Fax: _____

First day of last menstrual period (LMP): _____
EDD based on first dating ultrasound: _____

Previous Testing: If the following labs and ultrasound have already been done, please indicate and fax results with the completed referral

- □ *CBC and ferritin*
- □ *ABO blood group and antibodies*
- □ *Serologies: HIV, VZV IgG, rubella, HepBsAg, syphilis*
- □ *TSH*
- □ *Urine C&S*
- □ *Urine for chlamydia and gonorrhea*
- □ *First dating ultrasound between EGA 7-11 weeks*

We would appreciate it if you would discuss the availability of public and private pay genetic screening which is, as you know, time sensitive. Please attach results if done.

- □ *Genetic screening reports (NT, IPS, SIPS, QUAD, NIPT)*
- □ *Report pending* □ *Not discussed* □ *Declined*