Lions Gate Maternity Clinic PH: 604-985-6408

Date of Referral: _____

Patient Last Name: _____ First Name: _____

Address: _____

Contact Number: _____ Email: _____

DOB (YY/MM/DD): _____ PHN:_____

Additional Persons: _____

Please discuss the following **First Trimester Investigations** with your patient and forward the results to LGMC

▢ **First Dating Ultrasound** (between EGA 7-11 weeks) ▢ **CBC and Ferritin** ▢ **TSH** ▢ ABO **Blood Group and Antibodies:** Hemoglobin Electrophoresis (unless Japanese, Korean, First Nations, Inuit or Northern European Caucasian)	▢ **Serologies:** HIV, Rubella, Hep Bs Ag, Syphilis ▢ **VZV** (if varicella status unknown) ▢ **HCV** (if high risk) ▢ **Urine C&S** ▢ **Urine or Cervical:** Chlamydia & Gonorrhea ▢ **PAP** (most recent)

Prenatal Genetic Screening is time sensitive and should be discussed regardless of age. If you do not feel comfortable discussing this with your patient, please ensure they are referred to us as soon as possible.

NT, IPS, SIPS, QUAD, NIPT

▢ **Included** ▢ **Pending** ▢ **Not Discussed** ▢ **Declined**

Last Menstrual Period: _____ Estimated Due Date: _____

Referring Professional:_____Billing Number: _____

▢**Family Physician** ▢**Obstetrician** ▢**Midwife**

Phone: _____ Fax:_____

fax results and this completed form to 604-985-6108 or email lghmatclinic@gmail

for further information and recommendations about early pregnancy care please visit Perinatal Services of British Columbia