Peninsula Clinical Genetics Referral

Date of Referral			
Name of patient			
Date of Birth			
Hospital Number		NHS Number	
Address Postcode			
Phone Number Mobile Number			
GP			
GP Address			
Partner's Name			
Partner's Date of Birth			

Not pregnant / Pregnant	
LMP / Scan gestation / EDD	
Relevant details of previous pregnancies	Gravida. Para.
Disorder	
Relevant Family History *(Include name and dob birth of affected family member where possible. If Genetics reference number known please include this also)*	
Previous / pending investigations	
Prenatal diagnosis requested	Yes / No / Undecided
Appointment required	Yes / No

Referrer		Job title	
Contact no.		Hospital	
Consultant			
Fax number			

Please fax completed form

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