Diagnostic Ambulatory Program
Prenatal Procedures Unit
Tel (604) 875-2814
Fax (604) 875-2095

INTAKE FORM

for Advanced Maternal Age (AMA)

PLEASE COMPLETE IN FULL AND FAX
(will not book procedure if incomplete)

Procedure to book : ☐ **Amniocentesis**

☐ **C.V.S.** (Chorionic Villus Sampling)

Documents to be faxed with this form to complete the referral:

- Blood Type Report from Canadian Blood Services
- All Obstetrical Ultrasound Reports of current pregnancy
- Antenatal Record Part I & II
- Triple Screen Reports if done (FTS, IPSS, TMS, NT)
- Ultrasound Requisition if 19-wk detailed scan to be booked at BCWH
- For CVS referral also send Cervical Swab report for gonorrhea and Chlamydia

Date Referred:				Gestational Age on Referral :		
Any additional risk factors other AMA:						
G:	T:	P:	L:	A: SA	A:TA	Other:
On Heparin: Yes / No		Other Rx:				Multiple Gestation: Yes / No

Patient's Name:			
Address:			
Tel: Home	Work		Cellular
PHN	BCWH Unit #		
Date of Birth:	Age at EDC:		
Ref. Dr.	MSP #		Tel:
Address:			Fax:
Other Dr.	MSP #		Tel:
Address:			Fax:

LMP:		Are menstrual cycles regular? Yes/No _____ Days			
Dating Ultrasound: Date:		Location:			
CRL:	BPD:	Gestational Age:	Blood Type: Pos / Neg		
Will patient have *Triple Marker Screen* prior to amniocentesis?			Yes/No	If yes, date done/to be done:	
Does patient require an interpreter?	Yes/No	If yes, Language:	Ref #		
Person to contact in your office to inform appointment: Name:			Direct Line:		

*** If you do not get an appointment within 2 working days, please call to confirm if we have received your referral***