Referral form to Genetic Services

Form to be completed by maternity provider making the referral.

Family name		**First names**		
NHI number		**Date of birth**		
Patient DHB		**Patient phone numbers**	Daytime:	
LMP/EDD			Mobile:	
NZMC# or Midwifery Council #		**Date of referral**		
Referrer's phone number		**Referrer's fax number**		
GP/LMC making referral	Name (in block letters)			
	Address			
	Signature			
Reason for referral (please tick one)	☐ Family history (please provide details):			
	☐ More information required (please provide details):			
	☐ Other (please state)			
When (please tick one)	☐ Prior to consenting to antenatal screening for DS or other conditions			
	☐ After increased risk result first trimester combined screening			
	☐ After increased risk result second trimester maternal serum screening			
	☐ After positive diagnostic test result			
	☐ Other (please state)			
Background material attached (please tick):	☐ Copy of laboratory screening risk result report			
	☐ Other (please state)			

PLEASE RING OR FAX THIS REFERRAL TO:		
Northern and Midland Regional Genetic Services (located in Auckland)		
Toll free 0800 476 123	Telephone 09 307 4949 Extn 25870	Fax 09 307 4978
Central Regional Genetic Services (located in Wellington)		
Toll free 0800 0508 364 436	Telephone 04 385 5310	Fax 04 385 5822
Southern Regional Genetic Services (located in Christchurch)		
Toll free 0800 0508 364 436	Telephone 03 378 6574	Fax 03 379 1343