Centenary Genetics Clinic Referral Form

4th Floor, 2867 Ellesmere Road, Scarborough, Ontario M1E 4B9
Telephone: (416) 281-7425 Fax: (416) 281-7306

Referral Date: ______________________________ **Appt Date:** ____________________________

Patient Information

Name: ____

(Last) (First)

Address: ____

City: ____________________________ Postal Code: ________________________________

Home Tel: ____________________________ Bus Tel: ________________________________

HC # ____________________________ Version: ________________________________

DOB ______/_______/_______ (yy/mm/dd)

Clinical Information

The Centenary Genetics Clinic accepts referrals for prenatal, cancer and other indications.

Referral Diagnosis : ____

☐ AMA ☐ + IPS/MSS ☐ Abn U/S ☐ Thalassemia ☐ Consanguinity

To process your referral efficiently, we will require the following information to be faxed at the SAME TIME as this referral form to (416) 281-7306:

Prenatal Counselling:
1. Dating Ultrasound
2. Blood Group
3. Antenatal 1 Record
4. CBC/Hematology/Hb Electrophoresis (if available)

Cancer/Miscellaneous Counselling:
1. Brief family history
2. Familial Genetic Test Results (if applicable)
3. Pathology (if applicable)

Previous Genetic Counselling: ________ Yes _________ No

Familial Genetic Testing Performed: ________ Yes _________ No

Twin Pregnancy (if applicable): ________ Yes _________ No

Maternal Serum Screen Drawn (if applicable): ________ Yes _________ No

Physician Information

Referring Physician: ____

Physician Number: ____

Telephone No: ____

Fax No: ____

Please include a fax number, as an appointment will be faxed to the physician's office.