

GENERAL REFERRAL FORM

PLEASE COMPLETE IN FULL AND PRINT CLEARLY

Instructions: Please FAX the completed referral form with all associated medical records (see below) to 250-727-4295.

Faxing all relevant medical records with this form will enable us to process the referral in a timely manner.

**** The patient and/or referring professional will be notified by the Genetics Clinic of arrangements. ****

PATIENT'S NAME (SURNAME, FIRST, MIDDLE):		OTHER NAME:		DOB: (YY/MM/DD)	MRN #:
PHN:	MAIDEN NAME:	SEX:	AGE:	ETHNIC ORIGIN:	
ADDRESS:			HOME PHONE #:	WORK PHONE #:	
CITY:			POSTAL CODE:	ALTERNATE PHONE #:	
MOTHER'S NAME (SURNAME, FIRST, MIDDLE):		MOTHER'S MAIDEN NAME:		DOB :(YY/MM/DD)	
FATHER'S NAME (SURNAME, FIRST, MIDDLE):				DOB :(YY/MM/DD)	
PARTNER'S NAME (SURNAME, FIRST, MIDDLE):				DOB :(YY/MM/DD)	
HAS THIS FAMILY PREVIOUSLY BEEN SEEN IN MEDICAL GENETICS? <input type="checkbox"/> No <input type="checkbox"/> Yes → Name of Relative, and Program/City where seen?					
PLEASE SUPPLY NAMES AND BIRTHDATES OF OTHER AFFECTED FAMILY MEMBERS (IF APPLICABLE):					
IS THIS REFERRAL RELATED TO AN ONGOING PREGNANCY? <input type="checkbox"/> No <input type="checkbox"/> Yes → Please contact us to obtain a Prenatal Referral Form. IS THIS REFERRAL URGENT? (needs to be seen within 2 – 3 months) <input type="checkbox"/> No <input type="checkbox"/> Yes → Reason for urgency?					
REASON FOR REFERRAL - PLEASE PROVIDE DETAILS TO ENSURE PROMPT AND APPROPRIATE TRIAGE OF THIS REFERRAL					
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DOES THIS PATIENT REQUIRE AN INTERPRETER? <input type="checkbox"/> No <input type="checkbox"/> Yes → Which language?					
PLEASE ATTACH (if applicable) : <input type="checkbox"/> ALL SPECIALIST CONSULTATION LETTERS <input type="checkbox"/> ALL IMAGING REPORTS (MRI, CT, ULTRASOUND, X-RAYS) <input type="checkbox"/> ALL DEVELOPMENTAL / PSYCHOLOGICAL / EDUCATIONAL ASSESSMENTS <input type="checkbox"/> RECENT BLOOD TEST RESULTS <input type="checkbox"/> CHROMOSOME OR OTHER MOLECULAR GENETIC TESTING RESULTS <input type="checkbox"/> ALL SPECIAL TESTING (AUDIOLOGY, ERG, EMG, EEG, etc)					
REFERRING DOCTOR:		ADDRESS (STREET/CITY/POSTAL CODE)		PHONE #:	
MSP BILLING #:				FAX #:	
FAMILY DOCTOR:		ADDRESS: (STREET/CITY/POSTAL CODE)		PHONE #:	
MSP BILLING #:				FAX #:	
OTHER DOCTOR(S):					

**** Please keep photocopied form for future referrals. ****