Porcupine
Health Unit • Bureau de santé

General & Prenatal REFERRAL FORM Genetics Program

Referral Date:

PATIENT NAME: _____

DOB: _____ ☐ Male ☐ Female
yy / mm / dd

Health card #: _____
Version code

Expiry date: _____

Address: _____

_____
City Postal code

Home #: _____

Alternate #: _____

Parent/Guardian/contact: _____

Phone #: _____

☐ **Non-pregnant**
☐ **Pregnant**
GESTATION: _____
Required information: ultrasounds, CBC, group + screen, Antenatal 1, maternal screening results.

NEOFACS Involved
☐ **Yes**
☐ **No**
Child's Worker _____

REASON FOR REFERRAL: _____

_____

_____

Significant medical or family history: _____

_____

_____

Please attach blood work, imaging studies, consultation letters, genetic test results, etc.
This referral will be processed more efficiently if pertinent medical reports are sent <u>with</u> the referral.

REFERRING DOCTOR: _____ **Physician billing #:** _____

Address: _____

Phone # _____ **Fax #** _____

<u>PLEASE NOTE</u>:
☐ **Incomplete or illegible referrals will be returned to your office**
☐ **Some referrals may be declined based on referral criteria.**

<u>Please fax your form to the Genetics clinic at 705-268-4443</u>

Genetics Program, 273 Third Avenue, Suite 103, Timmins, Ontario P4N 1E2
Tel: 705-2671181 Fax: 705-268-4443 www.porcupinehu.on.ca

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