Referral Form for Genomic Consultation

Date of Referral: _____ (Day) _____ (Month) _____ (Year)

Patient Information

Last Name: _____ First Name: _____ Gender: Male ☐ Female ☐

Address: _____ DOB: _____

_____ PHN: _____

Phone: _____ Alt. Phone: _____ MRN: _____

Referring Physician

Last Name: _____ First Name: _____ Billing No. _____

Address: _____ Phone: _____

_____ Fax: _____

Reason for Referral:

(Please include how a diagnosis may impact patient care e.g. parents planning a pregnancy, treatment, medical decision)

_____

_____

Relevant clinical findings: _____

_____

Investigations – Genetic & others - Ordered & Results: _____

_____

Has this patient been evaluated in Medical Genetics? Yes ☐ No ☐

Other services involved: _____

Are both parents available for testing? Yes ☐ No ☐

Please confirm family is aware of referral Yes ☐

Tel: 604-875-2839 **Fax:** 604-875-2376

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