Medical Genetics
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Division of Medical Genetics
Referral Form

Patient information:

Full Legal Name (Last, First): _____

Birth/Maiden Name: _____ Date of birth (DD/MM/YY): _____

PHN: _____ If child, parents names: _____

If child is in foster care, name & contact number for social worker: _____

Current mailing address: _____
Street address, City, Province, Postal Code

Current phone number: _____ _____ _____
Home Work Cell

General Referral: Attach all relevant clinical reports and test results.

Reason: _____

_____

_____

Prenatal Referral: If available, attach:

- Prenatal Screening results for this pregnancy
- Results of all obstetric ultrasounds for this pregnancy
- Results of Amniocentesis and/or CVS
- Results of previous genetic testing

Reason for referral: _____

_____

LMP: _____ **EDC:** _____

Cancer Referral: If available, attach:

- Relevant clinical notes
- All screening reports
- Pathology reports for all primary site cancers
- Results of previous genetic testing / family members' genetic test results

Reason for referral: _____

_____

Has a family member previously seen Genetics? ☐ No ☐ Yes

If yes, Name: _____ Relationship: _____

Name of affected family member, if different from above: _____

Referring Physician Name: (Please print): _____