



Porcupine Health Unit Genetic Services
 273 Third Avenue, Suite #103, Timmins
 Postal Bag 2012, Timmins, Ontario, P4N 8B7
 Tel: (705) 267-1181 – Fax: (705) 268-4443

GENETIC REFERRAL

Surname:	First name:	DOB:
Health Card Number:		
Address:		
Town:		
Postal Code:		
Parent(s)/Spouse:		<input type="checkbox"/> N/A
Foster parent (s):		<input type="checkbox"/> N/A
Home telephone:		
Other telephone (specify):		
Primary health care provider:	telephone:	<input type="checkbox"/> N/A
Child's worker name:	telephone:	<input type="checkbox"/> N/A
Family worker's name:	telephone:	<input type="checkbox"/> N/A
Reason for referral:		
Family aware of referral? Yes () No ()		
Note: Please enclose or provide, as available, all medical documentation and records of assessments done previously or concurrently for the purpose of genetic assessment.		
Referred by: _____ Agency: _____		
Date:	Signature:	