Genetics
General and Prenatal Referral Form

Referral Date: _____YYYY-MM-DD_____
Is the patient (or guardian) aware that this referral has been made? ☐ **Yes** ☐ **No**

PLEASE NOTE:
Incomplete referrals will be returned to your office. Some referrals may be declined based on referral criteria. Please attach blood work, imaging studies, consultation letters, genetic test results, etc.

A family history questionnaire will be sent to your patient and must be completed prior to booking an appointment.
Is this referral urgent? ☐ **Yes** ☐ **No**
If yes, please indicate reason for urgency: _____

Is your patient currently pregnant? ☐ **Yes** ☐ **No** **If yes, please indicate LMP:** _____YYYY-MM-DD_____
** For all prenatal patients, please send ultrasounds, CBC, Group + Screen, Antenatal 1, Maternal Screening Results

Patient Information			
Name:		DOB: YYYY-MM-DD	Sex:
Health Card #:	Version Code:	Expiry Date: YYYY-MM-DD	
Address:	City:	Postal Code:	
Home Telephone #:	Mobile:	Work:	

Reason for Referral

Has this patient previously been seen in a genetics clinic? ☐ **Yes** ☐ **No**
If yes, please attach all relevant consultation notes and genetic test results.
Why: _____ When: _____YYYY-MM-DD_____
Name of Genetic Clinic: _____

Has a relative tested positive for a genetic condition? ☐ **Yes** ☐ **No**
If yes, please attach genetic test report confirming familial mutation.

Name of Relative	**Relationship to Patient**	**Gene**

Relevant Family History	
Relation to Patient	**Pertinent Medical History (diagnosis, birth defect, frequent miscarriage, etc.)**

Referring Health Care Provider		
Name:		Signature:
Telephone #:	Ext.	Fax #:
Address:		
Billing # :		CPSO #:

Please fax the completed form to the Porcupine Health Unit Genetics Clinic at 705-360-4801