North Simcoe Muskoka Regional Genetics Program
Cancer Genetics Referral Form

Telephone: (705) 327-9154 Fax: (705) 325-9459

Appt. Date & Time: _____ Location: _____

Surname: _____ First Name: _____

DOB: _____ (YY/MM/DD) MOH#: _____ Version: _____

Address & Postal Code: _____

Home Ph #: _____ Work Ph #: _____ Cell Ph #: _____

Parent or Spouse's Name: _____

Reason for referral: _____

Is this a referral for an OBSP high risk assessment: Yes No

Has case been reviewed by OBSP Nurse Navigator: Yes No

Has the patient had cancer her/himself: Yes No Family history of cancer: Yes No

Family member affected with cancer	Relationship to patient (e.g. maternal/paternal)	Primary type of cancer	Age at diagnosis
1.			
2.			
3.			
4.			
5.			
6.			

Records Requested	Sent with referral?			Date requested	Date received
Pathology report for patient	Yes	No	N/A	_____	_____
Pathology for family member	Yes	No	N/A	_____	_____
Other: _____	Yes	No	N/A	_____	_____
Other: _____	Yes	No	N/A	_____	_____

Referring Source/Specialty & Billing #: _____

Address & Postal Code: _____

Telephone: _____ Inside Line: _____ Fax: _____

Family Dr.: _____

Signature & Title: _____ Date & Time: _____