North Simcoe Muskoka Regional Genetics Program
General Genetics Referral Form

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

Appt. Date & Time: ________________________

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: ____

Current health concerns: ____

Current medications: ____

Family History: ____

Pregnant: Yes   No

Ultrasound: Date: ___________ (YY/MM/DD)   Place & Address: ________________________

# of fetuses: ____ BPD: _______ CRL: ______   Placenta: ______________   NT: _______ mm

LMP: _________ (YY/MM/DD)   EDC: __________ (YY/MM/DD)   Gestation: ____ w ____ d

Other:___________________________

Blood type: _____ Rh: _____   Documentation provided: Yes   No

Records Requested	Sent with referral?	Date requested	Date received
Ultrasound report	Yes No N/A	____________	____________
Blood Type & MCV	Yes No N/A	____________	____________
MSS/IPS/FTS Results	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: ____________________