



**ORILLIA SOLDIERS' MEMORIAL HOSPITAL  
GENETIC SERVICES - GENERAL REFERRAL**

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: \_\_\_\_\_