NORTH SIMCOE MUSKOKA REGIONAL GENETICS PROGRAM
GENERAL AND PRENATAL GENETICS REFERRAL FORM

Please fax form to: (705) 325-9459 Telephone: (705) 327-9154

PATIENT INFORMATION

Last name: ____ First Name: ________________________________

DOB: _________________ (YY/MM/DD) ☐ Male ☐ Female ☐ Other: ___________________

OHIP#: ___________________________________ Version: ______

Address: ____ City: ___________________Postal: ___________

Home #: _________________________ Work #: _______________________ Cell #: _______________________

REFERRAL INFORMATION

Reason for referral: ____

____

____

Urgency of referral: ☐ urgent (within 1-2 weeks) ☐ semi-urgent (2-3 months) ☐ routine

If urgent, please explain impact to care/reason for urgency:____

____

If relative previously seen in our clinic, please provide name and DOB: _______________________________________

*****Please include all consult notes and previous genetic testing results with referral (if applicable)*****

PREGNANCY INFORMATION

Pregnant: ☐ Yes ☐ No

Ultrasound: Date: ______________ (YY/MM/DD) Gestation: ____ weeks ____ days

# of fetuses: _____ BPD: __________ CRL: __________ NT: _________ mm

LMP: ______________ (YY/MM/DD) EDC: ______________ (YY/MM/DD)

Other results (NIPT, eFTS, etc.):____

Blood type: _____ Rh: _____

*****Include all ultrasounds, prenatal screening results, confirmation of blood type, CBC/MCV and other genetic test results*****

REFERRING PROVIDER INFORMATION

Name: ____ OHIP Billing #: ______________________

Address: ____ City: ____________________Postal: ____________

Telephone: ________________________ Inside Line: _________________________ Fax: _________________________

Signature: ________________________ Date: ___________________ Family Dr: ______________________________

OFFICE USE ONLY: Clinic: __________________ Date: ___________________________ Time:_________________________