Soldiers' MEMORIAL HOSPITAL Orillia

NORTH SIMCOE MUSKOKA REGIONAL GENETICS PROGRAM
CANCER 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:_____

_____

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

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

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

*****Please include all pathology reports, consult notes, and previous tumour/IHC/genetic testing results with this referral*****

FAMILY HISTORY OF CANCER

Family member affected	Relationship to patient (maternal/paternal)	Primary type of cancer	Age of dx

REFERRING PROVIDER INFORMATION

Name: _____ OHIP Billing #: _____

Address: _____ City: _____Postal: _____

Telephone: _____ Inside Line: _____ Fax: _____

Signature: _____ Date: _____ Family Dr: _____

OFFICE USE ONLY: Clinic: _____ Date: _____ Time: _____