Soldiers' MEMORIAL HOSPITAL Orillia

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:_____