

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 Na	me:	
DOB: (YY/MM/DD)			
OHIP#:Version:			
		Postal:	_
	Work #:		
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: \square Yes \square No Family history of cancer: \square Yes \square 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:	