Soldiers' MEMORIAL HOSPITAL Orillia

NORTH SIMCOE MUSKOKA REGIONAL GENETICS PROGRAM
GENERAL 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 ☐ semi-urgent ☐ routine

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

____

Has the patient had signs/symptoms themselves: ☐ Yes ☐ No Family history of the condition: ☐ Yes ☐ No

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

Please include all relevant reports, consult notes, and genetic testing results with this referral.
Incomplete referrals will not be accepted.
Please note: We are not able to accept prenatal genetics referrals at this time.

FAMILY HISTORY OF CONDITION

Family member affected	Relationship to patient (maternal/paternal)	Genetic testing done? (Y/N)	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:_______________________