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 #: _____

Email:_____

The patient's email address is <u>required</u> as a family history questionnaire will be sent to the patient. This information will be used to assess hereditary cancer risk as part of the patient's genetics assessment.

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 ****

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:_____