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 #: _____

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 risk as part of the patient's genetics assessment.

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:_____