Thunder Bay Regional Health Sciences Centre

GENETICS PROGRAM

REFERRAL FORM (GENERAL)

Place Patient Label with Barcode Here

Guidelines:

1. Complete all fields on the Genetics Program "General Referral Form" and fax to 807-684-5823.
2. Primary Care Provider must sign the form.
3. Referral form will be stored with the patient's chart in the Genetics Program.

Referral Date:

Name of Patient: **DOB**:

Health Card Number: **Version Code**

Address:

Phone: (Home): **(Work):** **(Cell):**

Contact Person (If applicable): **Relationship:**

Reason for Referral **Is Patient Pregnant?** ☐ **Yes** ☐ **No**

Health Care Provider Name: _____ Signature: _____

Address: _____ Fax Number: _____

Please include all relevant records (i.e. consult letters, investigations/bloodwork)

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