Thunder Bay Regional Health Sciences Centre

CLINICAL GENETICS PROGRAM

REFERRAL FORM (GENERAL/PRENATAL)

Patient Name: _____

D.O.B. (YYYY-MM-DD): _____

Address: _____

City/Town, Prov:_____

Postal Code: _____Tel: _____

Health Card #: _____ Version: ____

Guidelines for Completion:

1. Complete all fields and fax to 807-684-5823. **INCOMPLETE OR ILLEGIBLE FORMS MAY BE RETURNED.**
2. The referring Health Care Provider must sign the form.
3. To assist in triaging the referral, please include relevant records (e.g., consult letters, imaging, lab results, other relevant investigations).

Sex assigned at birth: _____ Gender: _____ Pronouns: _____/_____/_____

Are interpretation services required? ☐ Yes ☐ No If yes, for which language? _____

Alternate contact name (if applicable): _____

Relationship to patient: _____ Telephone (if different than patient):_____

Is this an urgent referral? ☐ Yes ☐ No (Urgent referrals will be prioritized)

If yes, please check one of the following: ☐ Genetic results will impact immediate medical treatment
☐ Patient is palliative
☐ Patient is pregnant*

***If the patient is pregnant**, please attach Antenatal Records 1 and 2, all prenatal ultrasounds, bloodwork and prenatal screening, if applicable.

Reason for Referral: _____

_____

_____

_____

_____

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_____

_____

Does the patient have a blood relative with a confirmed pathogenic or likely pathogenic variant in a gene? ☐ Yes ☐ No

If yes, please attach a copy of the genetic testing report or family letter (required prior to testing).

Referring Health Care Provider Information:

Name: _____ Signature: _____ Referral Date: _____

Address/Clinic/Facility: _____

Telephone #: _____ Fax # (to send correspondence/results): _____