PROVINCIAL MEDICAL GENETICS PROGRAM REFERRAL FORM

Children's & Women's Health Centre of B.C. 4500 Oak Street, Room C234, Vancouver, B.C. V6H 3N1 Telephone: (604) 875-2157

Instructions: Please complete and **FAX** the completed referral form with associated medical records to (**604) 875-2825.**
Faxing all relevant medical records with this form will enable us to process the referral in a timely manner.
Please PRINT clearly.

PATIENT'S SURNAME:	GIVEN NAME:	MIDDLE NAME:	DOB: (YY/MM/DD)
PHN:	MAIDEN NAME:	SEX:	AGE:

ADDRESS (STREET/CITY/POSTAL CODE):	HOME PHONE #:	WORK PHONE #:	ALTERNATE PHONE #:

MOTHER'S SURNAME :	GIVEN NAME:	DOB :(YY/MM/DD)
MOTHER'S PREVIOUS LAST NAME(S):		
FATHER'S SURNAME :	GIVEN NAME:	DOB :(YY/MM/DD)
PARTNER'S SURNAME:	GIVEN NAME:	DOB :(YY/MM/DD)

HAS THIS FAMILY PREVIOUSLY BEEN SEEN IN MEDICAL GENETICS? Yes ☐ No☐

PLEASE SUPPLY NAMES AND BIRTHDATES OF OTHER AFFECTED FAMILY MEMBERS (IF APPLICABLE):

IS THIS REFERRAL RELATED TO AN ONGOING PREGNANCY? Yes ☐ No☐

IS THIS REFERRAL URGENT? (needs to be seen within 2 – 3 months) Yes ☐ No☐ If yes, reason for urgency:

_____

REASON FOR REFERRAL - PLEASE PROVIDE DETAILS TO ENSURE PROMPT AND APPROPRIATE TRIAGE OF THIS REFERRAL

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DOES THIS PATIENT REQUIRE AN INTERPRETER? Yes ☐ No☐ IF YES, IN WHICH LANGUAGE? _____

PLEASE ATTACH (if applicable) :

☐ ALL SPECIALIST CONSULTATION LETTERS ☐ ALL IMAGING REPORTS (MRI, CT, ULTRASOUND, X-RAYS)

☐ ALL DEVELOPMENTAL / PSYCHOLOGICAL / EDUCATIONAL ASSESSMENTS ☐ RECENT BLOOD TEST RESULTS

☐ CHROMOSOME OR OTHER MOLECULAR GENETIC TESTING RESULTS ☐ALL SPECIAL TESTING (AUDIOLOGY, ERG, EMG, EEG, etc)

REFERRING DOCTOR:	ADDRESS (STREET/CITY/POSTAL CODE)	PHONE #:
BILLING #:		FAX #:
FAMILY DOCTOR:	ADDRESS: (STREET/CITY/POSTAL CODE)	PHONE #:
BILLING #:		FAX #:
OTHER DOCTOR(S):		