VANCOUVER ISLAND health authority

DEPARTMENT OF MEDICAL GENETICS
Victoria General Hospital
1 Hospital Way, Victoria, BC V8Z 6R5

Tel: (250) 727-4461
Fax: (250) 727-4295

GENERAL REFERRAL FORM
PLEASE COMPLETE IN FULL AND PRINT CLEARLY

Instructions: Please FAX the <u>completed referral form</u> with <u>all associated medical records</u> (see below) to <u>250-727-4295</u>.
Faxing all relevant medical records with this form will enable us to process the referral in a timely manner.
** The patient and/or referring professional will be notified by the Genetics Clinic of arrangements. **

PATIENT'S NAME (SURNAME, FIRST, MIDDLE):	OTHER NAME:	DOB: (YY/MM/DD)	MRN #:

PHN:	MAIDEN NAME:	SEX:	AGE:	ETHNIC ORIGIN:

ADDRESS:	HOME PHONE #:	WORK PHONE #:
CITY:	POSTAL CODE:	ALTERNATE PHONE #:

MOTHER'S NAME (SURNAME, FIRST, MIDDLE):	MOTHER'S MAIDEN NAME:	DOB :(YY/MM/DD)
FATHER'S NAME (SURNAME, FIRST, MIDDLE):		DOB :(YY/MM/DD)
PARTNER'S NAME (SURNAME, FIRST, MIDDLE):		DOB :(YY/MM/DD)

HAS THIS FAMILY PREVIOUSLY BEEN SEEN IN MEDICAL GENETICS? ☒ No   ☒ Yes → Name of Relative, and Program/City where seen?

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

IS THIS REFERRAL RELATED TO AN ONGOING PREGNANCY?   ☒ No   ☒ Yes → Please contact us to obtain a Prenatal Referral Form.
IS THIS REFERRAL URGENT? (needs to be seen within 2 – 3 months)   ☒ No   ☒ Yes → Reason for urgency?

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

_____

_____

_____

_____

_____

DOES THIS PATIENT REQUIRE AN INTERPRETER? ☒ No   ☒ Yes → 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 #:
MSP BILLING #:		FAX #:
FAMILY DOCTOR:	ADDRESS: (STREET/CITY/POSTAL CODE)	PHONE #:
MSP BILLING #:		FAX #:
OTHER DOCTOR(S):		

** Please keep photocopied form for future referrals. **   (August 2009)