MEDICAL GENETICS CLINIC
GENERAL REFERRAL FORM

Tel: (604) 875-2157
Fax: (604) 875-2825
Provincial Medical Genetics Program
B.C. Women's Hospital
Room C234, 4500 Oak Street, Vancouver, BC, V6H 3N1

BC Children's Hospital — An agency of the Provincial Health Services Authority
BC WOMEN'S HOSPITAL+ HEALTH CENTRE — An agency of the Provincial Health Services Authority

Referrals requiring our triaging attention within < 10 days should be called to 604-875-2157.
If referral concerns a **CURRENT PREGNANCY**, use form: http://www.bcwomens.ca/health-professionals/refer-a-patient/medical-genetics-pregnancy-assessment
If patient lives on **VANCOUVER ISLAND**, refer to: https://www.islandhealth.ca/our-services/medical-genetics-services/medical-genetics-services
If referral is of an **ADULT (>18) FOR A HEREDITARY CANCER ASSESSMENT**, refer to: http://www.bccancer.bc.ca/coping-and-support-site/Documents/Hereditary%20Cancer%20Program/HCP_Form-ReferralForm.pdf

Date of referral (DD/MM/YY): _____ Affirm patient is aware of referral ☐ Language of interpreter if needed _____

Name (Last, First):_____PHN: _____DOB (DD/MM/YY): _____

Home Address: _____Email Address: _____Postal Code:_____

Primary Tel:☐ home ☐ cell ☐ work_____Alt Tel: ☐ home☐ cell☐ work _____

Contact Person (if not patient) Name:_____ Tel:_____ Relation to patient: _____

Other relevant family member's Name:_____ Tel:_____ Relation to patient: _____

IMPORTANT: REFERRALS WITHOUT A SPECIFIC CLINICAL QUESTION AND REQUIRED RECORDS WILL BE DECLINED.

CLINICAL QUESTION *AND* RATIONAL FOR CONSULTATION:

_____

_____

_____

_____

SELECT PREDOMINANT CARE NEED: ☐ Diagnosis ☐ Variant Interpretation ☐ Management ☐ Family Implications/ Planning

REQUIRED INFORMATION:

ALL patients
- ☐ Relevant consultation notes
- ☐ Results from completed genetic testing
  Circle: Fragile X / Chromosome microarray/ Panel / Whole Exome Sequencing / Other
- ☐ Relevant investigations (e.g., imaging)

Referrals about a FAMILY HISTORY
- ☐ Diagnosis in family___ _____
- ☐ Describe how affected person(s) are related to your patient

_____
- ☐ Provide relevant records with a completed Release of Information consent form for affected family members: http://www.bcchildrens.ca/your-visit-site/Documents/Release%20of%20Information%20Form.pdf

Referrals for GENETIC CONNECTIVE TISSUE Disease
(including possible **MARFAN** syndrome)
- ☐ Echocardiogram
- ☐ Ophthalmology consultation notes
- ☐ For possible Marfan syndrome referrals, the systemic score (*marfan.org/dx*)

Referrals regarding NEURODEVELOPMENT
- ☐ Completed developmental assessments (including psychoeducational testing, autism assessments, and/or other)

Referrals for VARIANT interpretation support where parental testing has been recommended
- ☐ Parental familial variant testing reports, or
- ☐ Confirmation that parental testing will not be available

REFERRING DOCTOR:		OTHER DOCTOR:	
BILLING NUMBER:		BILLING NUMBER:	
ADDRESS:		ADDRESS:	
PHONE NUMBER:		PHONE NUMBER:	
FAX NUMBER:		FAX NUMBER:	

In making a referral, referrer maintains responsibility to be available to the patient in the event in-person care is needed.
Our referral criteria and instructions are periodically updated, please use the up to date version of this form.

CONSENT FORM FOR RELEASE OF PERSONAL INFORMATION

Your privacy is very important to us. Children's & Women's Health Centre of BC (C&W) wants to make sure your personal health information remains safe and protected.

This is a consent form for release of personal information. It is important that you understand:

1) Getting your personal health information by email or text message may not always be secure. Your email/phone could be broken into and your personal health information could be seen or shared with others or changed without your permission. We recommend deleting personal health information from your email or phone to reduce the risk to you.

2) Depending on what company your cell phone plan or email is with (such as Gmail or Yahoo), information we send to you may be stored outside of Canada.

3) If you delete email or text messages from C&W, backup copies could still be on your computer or in cyberspace.

4) C&W Staff do not check email and texts every day. If you need to talk to staff in an urgent situation please call your child's physician and/or family physician or seek care at your closest walk in clinic or emergency department.

5) Do not email or text the C&W if you have an emergency. If you have an emergency, call 911 or go to the closest emergency department.

6) C&W Staff will not give your health advice by email or text; you have to call or come into the clinic if you have questions about your health.

7) It is your responsibility to let us know if your email address or phone number changes.

8) It is your responsibility to tell the C&W if you change your mind and no longer want to get messages by email or text.

Please select one or more options below:

☐ I agree to provide my email and/or text (cell phone) message number for administrative purposes (i.e. scheduling appointments, test reminders) where small amount of personal information may be shared.

☐ I agree to send and receive consent forms that require my signature for coordination of genetic testing. *Information of these forms may include*

- Personal information such as name, date of birth, address, phone number, personal health number (information of family members if requested)
- My diagnosis, name of genetic testing and specimen type (information of family members if part of genetic testing) **– requires encryption**

CONSENT FORM FOR RELEASE OF PERSONAL INFORMATION

Placement of PATIENT ID LABEL

☐ I agree to provide my email and/or text (cell phone) message number for administrative purposes/general inquiries (including requests to contact C&W)/health education or promotion purposes. No personal health information will be shared

☐ By signing below, I agree to provide my email and/or text (cell phone) message number for the purpose of sharing my/my child's (less than 12 years of age) personal health information

Email address ***(print clearly)***:_____

Signatures:
This consent is not valid if signature and date is not provided*

_____ _____
Patient (or substitute decision maker*) signature | Witness Signature

_____ _____
Patient Name or Substitute Decision Maker*(Print) | Witness Name (Print)

_____
Reason for Substitute

_____/_____/_____
Day Month Year

_____/_____/_____
Day Month Year

* For the purpose of this consent a substitute decision maker may only be a family member or other legally appointed decision maker (e.g.: Representative, Committee, guardian)

TO BE COMPLETED BY THE INTERPRETER (if applicable):

I confirm that I have explained the nature of the above consent to the above-named patient (and/or legal substitute) in the presence of_____and to the best of my knowledge the context of this consent.
Witness Name (Print)

_____ _____/_____/_____
Signature of Interpreter | Day Month Year

_____
Interpreter Name (Print)

All information collection is done in accordance with section 26(c) the *Freedom of Information and Protection of Privacy Act.* If you have any questions about how your personal information is used or stored, please contact the Corporate Director, Information Access & Privacy at (604) 707-5834