



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: _____ Referral Source: _____

Patient aware of referral? (please circle one) Yes No

Name of Patient: _____ DOB: _____

OHCN: _____

Address: _____

Phone (H): _____ (W): _____

Contact Person: _____ Relationship: _____

Reason for Referral _____

For Referring Physician Use Only *Please include pathology reports with referral if available*

Physician Name: _____ Signature: _____ Date: _____

For Genetics Use Only

Does the patient fulfill referral criteria? Yes No

Genetics Nurse: _____ Date: _____

* The consulting geneticist will require documentation of investigations/consultations. It would be helpful to have pertinent medical records accompany this referral.



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