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.

TGENREFGENRL