

Genetics Program Referral

1 Hospital Drive, Peterborough, ON K9J 7C6

Fax: 705-876-5129

Phone: 705-743-2121 x 2879

Surname: _____ First Name: _____ Gender: M F

Date of Birth: (dd/mm/yyyy): ____ / ____ / ____ Health Card Number: _____

Parent/Guardian: _____

Home Phone: (____) _____ Bus. Phone: (____) _____

Address: _____ Postal Code: _____

Has the patient been referred to a genetics centre before? No Yes Where? _____

Early Prenatal Genetic Service: LMP: (dd/mm/yyyy) ____ / ____ / ____ P__ G__ TA__ SA__

Education, and organization of prenatal genetic screening/diagnostic tests (*optimal referral 7-10 weeks gestation*)

Prenatal referrals should include the following reports (if available)

- Blood type, CBC, dating ultrasound, antenatal record

Other Prenatal Referral: LMP: (dd/mm/yyyy) ____ / ____ / ____ P__ G__ TA__ SA__

Positive screen, increased nuchal translucency measurement, family history of genetic condition

Prenatal referrals should include the following reports (if available)

- Blood type, CBC, prenatal screening results, ultrasound(s), antenatal record

Additional information: _____

General Referral: Include diagnoses, consult letters and test results, and family history

Cancer Referral: Include diagnoses, pathology reports, and family history

Referral requested by: (please print or use stamp)

Name: _____ Billing#: _____

Tel: (____) _____ Fax: (____) _____

Date: (dd/mm/yyyy) ____ / ____ / ____ Signature: _____