PRHC
Peterborough Regional Health Centre

Patient Label

Genetics Program Referral

1 Hospital Drive, Peterborough, ON K9J 7C6

Fax: 705-876-5129 Phone: 705-876-5185

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: ____/____/____ Signature: _____
dd mm yyyy