NORTH YORK GENERAL

Making a World of Difference

REFERRAL FORM
Genetics Program

Referral Date:

PATIENT NAME: ______________________

DOB: ______________________ ☐ **Male** ☐ **Female**
yy / mm / dd

Health card #:______________________
Version code

Address: ______________________

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City Postal code

Home #: ______________________

Alternate #: ______________________

Parent/Guardian/contact: ______________________

Phone #:______________________

☐ **Non-pregnant**
☐ **Pregnant**
LMP: ______________
Required information: ultrasounds, CBC, group + screen, Antenatal 1, maternal screening results.

Interpreter needed:
☐ **No**
☐ **Yes**
Language: ______________

REASON FOR REFERRAL: ______________________

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Significant medical or family history: ______________________

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Please attach blood work, imaging studies, consultation letters, genetic test results, etc.

This referral will be processed more efficiently if pertinent medical reports are sent with the referral.

REFERRING DOCTOR:______________________ **Physician billing #:**______________

Address:______________________

Phone # ______________________**Fax #**______________________

PLEASE NOTE:

- ★ **Incomplete or illegible referrals will be returned to your office**
- ★ **Some referrals may be declined based on referral criteria.**

Please fax your form to the Genetics clinic at 416-756-6727

Genetics, 3rd Floor, South East Wing, 4001 Leslie Street Toronto, Ontario M2K 1E1
Tel: 416-756-6345 Fax: 416-756-6727 www.nygh.on.ca

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