NORTH YORK GENERAL

Making a World of Difference

REFERRAL FORM
Genetics Program

IMPORTANT:

★ **Incomplete referrals will not be accepted**

★ **Some referrals may be declined based on referral criteria.**

Does the patient speak English?

☐ **Yes** ☐ **No- specify language**

____

**Note: Clinic does not provide interpreters

Referral Date:

PATIENT NAME: ______________________________

DOB: ____________________ ☐ **Male** ☐ **Female**

yy / mm / dd

Health card #: ______________________________

Version code

Address: ______________________________

____

City Postal code

Primary Daytime #: ______________________________

Alternate #: ______________________________

Primary Parent/Guardian/contact: ____________________

Daytime #: ______________________________

Is Patient aware of this referral? ☐ **Yes** ☐ **No**

☐ **Non-pregnant**

☐ **Pregnant LMP:** ____________

For all pregnant patients it is **MANDATORY** to provide the Ultrasounds, CBC, Group + Screen, Antenatal 1, Maternal Screening Results **along with referral.**

REASON FOR REFERRAL:

____

____

____

Significant medical or family history:

____

____

____

Please attach all relevant information (i.e. blood work, imaging studies, consultation letters, genetic test results, etc.) to help us triage more urgent referrals and appropriate appointment booking.

REFERRING DOCTOR: ____________________ **Physician billing #:** ____________

Address: ______________________________

Phone # ____________________ **Fax #** ____________________

Signature: ____________________ ☐ **I agree this referral contains all relevant information.**

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

April 2019