London Health Sciences Centre

800 Commissioners Road East P.O. Box 5010
London, ON Canada N6A 5W9
Tel: 519-685-8500 ex. 58140 Fax: 519-685-8214

Medical Genetics – Referral Form

PLEASE FAX COMPLETED REFERRAL FORM TO 519-685-8214

PLEASE INCLUDE THE FOLLOWING RELEVANT HEALTH RECORDS

1. Results of any genetic testing previously done
2. Specialist consultation letters
3. Developmental assessments
4. Any relevant imaging and laboratory reports

Referral Process:

Each referral is assessed by a genetic counsellor who determines which records are required for the consultation. **The referral will be processed more efficiently if all relevant records are included**. The family will be sent a family history questionnaire to complete and return to us. The family history questionnaire is also located on our website. Referrals will be processed faster if this is filled out and sent with the referral. Once the questionnaire is returned to us an appointment will be made.

******THE PATIENT WILL BE CONTACTED WITH THE APPOINTMENT DATE AND TIME******

If the questionnaire is not returned within 3 months, your office will be notified that the referral has been cancelled.
If you feel there is a reason your patient cannot complete the questionnaire or if the referral is urgent please contact us directly to make alternate arrangements.

****Note**** If parents are requesting genetic counselling because they have a previous child with concerns, the child (if living) also needs to be referred for an assessment appointment.

PATIENT NAME: ______________________________ **DOB (YYYY/MM/DD):** ____________________

HEALTH CARD NUMBER: ____________________ **GENDER (Circle): MALE / FEMALE AGE:** __________

ADDRESS: ______________________________ **POSTAL CODE:** ____________________

______________________________ **PHONE:** ____________________

______________________________ **ALT NUMBER:** ____________________

EMAIL: ____

REASON FOR REFFERAL: ☐ **GENERAL GENETICS** ☐ **METABOLIC GENETICS** ☐ ***URGENT***

*If urgent, please call 519-685-8140 and ask to speak to the Genetic Counsellor on call.

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Additional relevant medical and/or family history (Please add names of other family members seen in our Genetics Clinic)

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INTERPRETER REQUIRED: ☐ YES ☐ NO **LANGUAGE:** ____________________

Referring Physician: ______________________________

Address: ______________________________

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Phone Number: ______________________________

Fax Number: ______________________________

For more information about our clinic please visit: ***http://www.lhsc.on.ca/Patients_Families_Visitors/Genetics/***