

MEDICAL GENETICS REFERRAL FORM

Please note: Incomplete and/or illegible forms may be returned to originating office, resulting in delays to the patient's appointment.

Genetics File #: _____
(office use only)

****If a referral is urgent, phone notification in addition to faxing is recommended.**

**For non-urgent cases the average wait time to see a Genetic Counsellor is approximately three weeks.

**Appointments for Medical Geneticists are triaged based on urgency.

Referral for: (If known, please mark off one or both below)

- Medical Geneticist (diagnostic service requested)
 Genetic Counsellor (diagnosis established in patient/family member and education service requested)

Referral Date: _____

Patient Name: _____ Maiden: _____

Parent/Guardian (if applicable): _____

DOB (M/D/Y): _____ PHN: _____ Gender: M / F

UAH #: _____ Other #: _____

Address: _____ PC: _____

Telephone #: (Home) _____ (Alternate/Work) _____

Referring Physician: _____ Tel #: _____ Fax #: _____

Address: _____ PC: _____

Reason for Referral / History : _____

Has the patient been seen previously in the Edmonton Genetics Clinic? Yes ___ No ___

Is the patient/guardian aware of referral? Yes ___ No ___

Does the patient require an interpreter? Yes ___ No ___

Is the patient pregnant? Yes ___ No ___

LMP (M/D/Y): _____

Referred to Maternal Fetal Medicine Clinic: Y/N

Pregnancy history/Ultrasound reports/Serum screening enclosed: Y/N

Total Pages sent: _____

Physician Signature

Please return completed form to:

Medical Genetics Clinic
8-53 Medical Sciences Building
University of Alberta
Edmonton AB T6G 2H7
Phone: 780-407-7333 Fax: 780-407-6845