Alberta Health Services

Clinical and Metabolic Genetics Program Referral

Last Name	First Name
Birthday *(yyyy-Mon-dd)*	
Gender	
PHN #	

***Southern Alberta, Including Red Deer**	**Mailing Address**
☐ Clinical Genetic referrals fax to **403-476-8752** ☐ Metabolic referrals fax to **403-955-3091** ☐ Referrals with *immediate pregnancy management implications* fax to **403-943-8376**	Alberta Children's Hospital 28 Oki Drive NW, Calgary, AB T3B 6A8 *Clinical Genetics* **403-955-7373** *Metabolic Clinic* **403-955-7587**
Northern Alberta *(all areas north of Red Deer including the Northwest Territories and Nunavut)	**Mailing Address**
☐ Clinical Genetic/Metabolic referrals fax to **780-407-6845** ☐ Referrals with *immediate pregnancy management implications* fax to **780-735-4814**	8-53 Medical Sciences Building University of Alberta 8440 – 112 Street NW Edmonton, AB T6G 2H7 Telephone: **780-407-7333** Toll-free: **1-855-935-7333**

***Patients may be offered an appointment at a site that best meets their needs**

Date of Referral *(yyyy-Mon-dd)*	Is an interpreter required? ☐ No ☐ Yes, If **"Yes"**, specify language/dialect _____

Is this referral urgent? ☐ No ☐ Yes, specify reason for urgency

Note: If the patient's condition changes and becomes urgent, immediately contact the appropriate clinic.

Is your patient/patient's partner pregnant? ☐ No ☐ Yes if so, LMP *(yyyy-Mon-dd)*:_____

Referring Physician

Physician/Designate *(Last, First name)*:			
Clinic Name			
Address	City	Province	Postal Code
Telephone Number / Fax Number	Family Physician, if different than above *(Last,First name)*:		

Patient Demographics

Address	City	Province	Postal Code
Best Daytime Phone Number	Alternate Phone Number		
Email address *(required to collect relevant family history information, schedule appointments and send appointment reminders.)*			
Name of Legal Guardian(s), if patient cannot consent *(Last, First name)*			

Guardian(s) Relationship to Patient

☐ Biological Parent(s) ☐ Legal Guardian(s) ☐ Social Worker ☐ Other *(please indicate)*_____

Is Patient in Foster Care? ☐ No ☐ Yes

Foster Parent *(Last, First name)*	Phone Number
Social Worker *(Last, First name)*	Phone Number

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Reason for Referral *Please include significant / relevant patient medical and family history*

Does your patient have any relatives affected by the conditions related to this referral?.
☐ No ☐ Unsure ☐ Yes If ***"Yes"*** please list all relatives and their relationship to the patient in the above "Reason for Referral Section"

Confirmation of relatives diagnosis, including genetic test results, consult letters, other relevant investigations ***attached*** ☐ No ☐ Yes

Requirements for Triage *Please include all relevant documentation on the patient if not available on Netcare*

• Molecular, biochemical genetic, cytogenetic laboratory results	☐ Attached	☐ Pending
• Other laboratory results	☐ Attached	☐ Pending
• Diagnostic imaging reports	☐ Attached	☐ Pending
• Other relevant investigations or assessments	☐ Attached	☐ Pending
• List of current medications	☐ Attached	☐ Pending
• Relevant consultation notes	☐ Attached	☐ Pending

Has your patient been previously seen by a Genetics Clinic?
☐ No ☐ I do not know ☐ Yes If ***"Yes"***, Name Genetics Clinic/Location of Facility (Patient's Genetics ID if known) _____

Genetics consult ***attached*** ☐ No ☐ Yes ☐ Pending

Pediatric Patients

Patient's place of birth	Birth records attached ☐ No ☐ Yes
Name of Hospital	
City/Province/State	Country
Completed by *(Last, First name)*	Designation
Signature	Date*(yyyy-Mon-dd)*