MEDICAL GENETICS CLINIC
GENERAL REFERRAL FORM

Tel: (604) 875-2157
Fax: (604) 875-2825
Provincial Medical Genetics Program
B.C. Children's Hospital
Room C234, 4500 Oak Street, Vancouver, BC, V6H 3N1

BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

IMPORTANT: COMPLETE FORM IN FULL & FAX ALL RELEVANT RECORDS TO 604-875-2825

1. All relevant reports and consults
2. All developmental/psychological/educational assessment
3. Chromosome or molecular genetic testing results
4. Any recent blood or pathology results
5. Imaging reports (ie MRI, x-ray, etc)
6. Other tests (ie audiology, ERG, EEG, etc)

**** YOUR PATIENT WILL BE NOTIFIED OF THE APPROXIMATE WAITLIST TIMEFRAME ****

COMPLETE PATIENT INFO

DATE OF REFERRAL _____

_____ _____ _____ _____
(PATIENT SURNAME, FIRST) (PREVIOUS / MAIDEN NAME) (DOB: YY/MM/DD) (AGE) (PHN)

_____ _____ _____ _____ _____
(ADDRESS) (EMAIL ADDRESS) (HOME PHONE) (WORK PHONE) (CELL PHONE)

COMPLETE FAMILY INFO

_____ _____
(MOTHER'S SURNAME, FIRST) (PREVIOUS/MAIDEN NAME) (DOB) (FATHER'S SURNAME, FIRST) (DOB)

_____ _____
(RELEVANT FAMILY MEMBER: SURNAME, FIRST) (DOB) (RELEVANT FAMILY MEMBER: SURNAME, FIRST) (DOB)

_____ _____ _____ _____
(PARTNER'S SURNAME, FIRST) (PREVIOUS / MAIDEN NAME) (DOB: YY/MM/DD) (AGE) (PHN)

Is this referral urgent (needs to be seen within 3 months?)	☐ NO	☐ YES ➔ *please provide info below*
Is this referral regarding a current pregnancy?	☐ NO	☐ YES
Does this patient need an interpreter?	☐ NO	☐ YES: _____ *(language)*
Have the family or relative been seen in Medical Genetics?	☐ NO	☐ YES
Is this referral to a specific Geneticist?	☐ NO	☐ YES: _____
Is the patient MRSA Positive?	☐ NO	☐ YES

REASON FOR REFERRAL

REFERRING DOCTOR :	OTHER DOCTOR:
BILLING NO:	BILLING NO:
ADDRESS:	ADDRESS:
PHONE NUMBER:	PHONE NUMBER:
FAX NUMBER:	FAX NUMBER: