MEDICAL GENETICS CLINIC **Tel: (604) 875-2157**
GENERAL REFERRAL FORM **Fax: (604) 875-2825**
Provincial Medical Genetics Program
B.C. Women'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

If referral concerns a **CURRENT PREGNANCY**, use form: http://www.bcwomens.ca/health-professionals/refer-a-patient/medical-genetics-pregnancy-assessment
If patient lives on **VANCOUVER ISLAND**, refer to: https://www.islandhealth.ca/our-services/medical-genetics-services/medical-genetics-services
If referral is of an **ADULT (+18) FOR A HEREDITARY CANCER ASSESSMENT**, refer to: http://www.bccancer.bc.ca/coping-and-support-site/Documents/Hereditary%20Cancer%20Program/HCP_Form-ReferralForm.pdf

Date of referral (DD/MM/YY): _____ Affirm patient is aware of referral ☐ Language of interpreter if needed _____

Name (Last, First):_____ DOB (DD/MM/YY): _____

Home Address: _____Email Address: _____Postal Code:_____

Primary Tel: ☐ home ☐ cell ☐ work_____Alt Tel: ☐ home ☐ cell ☐ work _____

Contact Person (if not patient) Name:_____ Tel:_____ Relation to patient: _____

Other relevant family member's Name:_____ Tel:_____ Relation to patient: _____

IMPORTANT: REFERRALS WITHOUT A SPECIFIC CLINICAL QUESTION AND REQUIRED RECORDS WILL BE DECLINED.

CLINICAL QUESTION *AND* RATIONALE FOR CONSULTATION:

_____

_____

_____

_____

SELECT PREDOMINANT CARE NEED: ☐ Diagnosis ☐ Variant Interpretation ☐ Management ☐ Family Implications/ Planning

REQUIRED INFORMATION:

ALL patients
- ☐ Relevant consultation notes
- ☐ Results from completed genetic testing
  Circle: Fragile X / Chromosome microarray/ Panel / Whole Exome Sequencing / Other
- ☐ Relevant investigations (e.g., imaging)

Referrals about a FAMILY HISTORY
- ☐ Diagnosis in family___ _____
- ☐ Describe how affected person(s) are related to your patient

_____
- ☐ Provide relevant records with a completed Release of Information consent form for affected family members: http://www.bcchildrens.ca/your-visit-site/Documents/Release%20of%20Information%20Form.pdf

Referrals for GENETIC CONNECTIVE TISSUE Disease
(including possible **MARFAN** syndrome)
- ☐ Echocardiogram
- ☐ Ophthalmology consultation notes
- ☐ For possible Marfan syndrome referrals, the systemic score (*marfan.org/dx*)

Referrals regarding NEURODEVELOPMENT
- ☐ Completed developmental assessments (including psychoeducational testing, autism assessments, and/or other)

Referrals for VARIANT interpretation support where parental testing has been recommended
- ☐ Parental familial variant testing reports, or
- ☐ Confirmation that parental testing will not be available

REFERRING DOCTOR:		OTHER DOCTOR:	
BILLING NUMBER:		BILLING NUMBER:	
ADDRESS:		ADDRESS:	
PHONE NUMBER:		PHONE NUMBER:	
FAX NUMBER:		FAX NUMBER:	

In making a referral, referrer maintains responsibility to be available to the patient in the event in-person care is needed.