MEDICAL GENETICS CLINIC
GENERAL REFERRAL FORM

Tel: (604) 875-2157
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:

_____

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_____

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_____ ☐ ☐ ☐ ☐ _____

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.