



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](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): \_\_\_\_\_ PHN: \_\_\_\_\_  
 DOB (DD/MM/YY): \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Home 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:  
<https://www.bcchildrens.ca/sites/g/files/qpdaav156/files/2025-01/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](http://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.**