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

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 OFFICE & 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) (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: ____________________

REASON FOR REFERRAL

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

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