PSYCHIATRIC GENETICS CLINIC
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

DATE OF REFERRAL: _____

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

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

Reason for referral or psychiatric diagnosis:

Please list current medications: _____

Any family or relative seen in Medical Genetics? □ NO □ YES: _____*(name/DOB)*

Does this patient need an interpreter? □ NO □ YES: _____*(language)*

Is this referral regarding a current pregnancy? □ NO □ YES: _____*(LMP date)*

REFERRING DR:	FAMILY DR:
BILLING NO:	BILLING NO:
ADDRESS:	ADDRESS:
PHONE NUMBER:	PHONE NUMBER:
FAX NUMBER:	FAX NUMBER:

Please list any other doctors involved with patient's care:

Please forward all relevant consults, reports and tests