



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): _____ 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:
<http://www.bccchildrens.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.