



**Medical Genetics Program of Southwestern Ontario**

**Tel: 519-685-8140 Fax: 519-685-8214**

**[http://www.lhsc.on.ca/About Us/Genetics/](http://www.lhsc.on.ca/About_Us/Genetics/)**

**DEMOGRAPHIC INFORMATION**

Please complete the following information about the person being referred to our clinic. The information given by you on this form will be kept on file in the Genetics clinic only.

Name of individual referred: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Sex:  Male  Female

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone number: (home) \_\_\_\_\_ (work) \_\_\_\_\_  
(cell) \_\_\_\_\_

Name of Referring Physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Phone number: \_\_\_\_\_

Please list the name and phone number of any additional physicians who require a copy of the results and consult letters regarding your visit to genetics: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Parent or Legal Guardian, if applicable: \_\_\_\_\_

Phone number: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name of Person Completing this form: \_\_\_\_\_

Relationship to individual referred: \_\_\_\_\_ Date: \_\_\_\_\_