London Health Sciences Centre

800 Commissioners Rd East
PO Box 5010
London ON N6A 5W9
Tel (519) 685-8140 Fax (519) 685-8214

Medical Genetics – Referral Form

PLEASE FAX COMPLETED REFERRAL FORM TO (519) 685-8214
PLEASE INCLUDE ALL RELEVANT HEALTH RECORDS

1. Results of any genetic testing done previously
2. Specialist consultation letters
3. Developmental assessments
4. Any relevant imaging and laboratory reports

Referral process: each referral is assessed by a genetic counsellor who determines which records are required for the consultation. **The referral will be processed more efficiently if all relevant records are included**. The family is sent a family history questionnaire to complete and return to us. Once the questionnaire is returned an appointment will be made ***YOUR OFFICE (not the patient) WILL BE CONTACTED WITH THE APPOINTMENT DATES***.
If the questionnaire is not returned within one month, your office will be notified that the referral has been canceled.
If you feel there is a reason your patient cannot complete the questionnaire or if the referral is urgent please contact us directly to make alternate arrangements.
Note if parents are requesting genetic counselling because of a previous child with concerns, the child (if living) needs to be referred for an assessment appointment.

PATIENT NAME: _____ DOB (YY/MM/DD) _____
HEALTH CARD NUMBER_____AGE: _____
ADDRESS_____PHONE _____
_____ALT NUMBER_____
_____ POSTAL CODE_____
EMAIL_____

REASON FOR REFFERAL: ☐ **GENERAL GENETICS** ☐ **METABOLIC GENETICS**

☐ ***URGENT*** Please call 519-685-8140 and ask to speak to the Genetic Counsellor on call

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Additional relevant medical and/or family history (please add names of other family members seen in our genetics clinic)

_____

INTERPRETER REQUIRED ☐ YES ☐ NO LANGUAGE_____

REFERRING PHYSICIAN _____
ADDRESS _____
_____
_____
PHONE NUMBER (_____)_____
FAX NUMBER (_____)_____