London Health Sciences Centre

Medical Genetics Program of Southwestern Ontario
Tel: 519-685-8140 Fax: 519-685-8214

DEMOGRAPHIC INFORMATION

Please complete the following information on the individual being referred to our clinic. The information provided 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
☐ Other: _____

Address: _____

_____

Phone number: (home) _____ (work) _____

(cell) _____

Reason for referral: _____

_____

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: _____