London Health Sciences Centre

800 Commissioners Road East P.O. Box 5010
London, ON Canada N6A 5W9
Tel: 519-685-8500 ex. 58140 Fax: 519-685-8214

Medical Genetics – Referral Form

PLEASE FAX COMPLETED REFERRAL FORM TO 519-685-8214
PLEASE INCLUDE THE FOLLOWING RELEVANT HEALTH RECORDS

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

******THE PATIENT WILL BE CONTACTED WITH THE APPOINTMENT DATE AND TIME******

Please indicate whether patient would like to be seen in Windsor or London clinic below. If clinic location is not indicated, clinic closest to patient's address will be assumed. Patients requiring an urgent appointment as determined by a genetic counsellor/geneticist will be seen in London only.

PATIENT NAME: _____ **DOB (YYYY/MM/DD):**_____

HEALTH CARD NUMBER: _____ **GENDER (Circle): MALE / FEMALE AGE:** _____

ADDRESS: _____ **POSTAL CODE:** _____

_____ **PHONE:** _____

_____ **ALT NUMBER:** _____

EMAIL: _____

CLINIC LOCATION: ☐ **Windsor (please note Windsor wait times may be longer)** ☐ **London**

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

*If 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: _____ **Date:** _____

Address: _____

_____

_____

Phone Number: _____

Fax Number: _____

For more information about our clinic please visit: ***http://www.lhsc.on.ca/Patients_Families_Visitors/Genetics/***