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******

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

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

ADDRESS: _____ **POSTAL CODE:** _____

_____ **PHONE:** _____

_____ **ALT NUMBER:** _____

EMAIL: _____

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

_____

_____

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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: _____

V. 2023.09.21