PETERBOROUGH REGIONAL HEALTH CENTRE

Genetics Program Referral

Fax: 705-876-5129 | Phone: 705-876-5185

PATIENT LABEL

Surname: _____ First Name: _____ Gender: ☐ M ☐ F

Date of Birth (DD/MM/YYYY): _____ Health Card Number: _____

Parent/Guardian: _____

Home Phone: _____ Bus. Phone: _____

Address: _____ Postal Code: _____

Has the patient been referred to a Genetics Centre before? ☐ No ☐ Yes, Where? _____

☐ **Prenatal Referral:**

LMP: Date of Birth (DD/MM/YYYY): _____ P____ G ____ TA ____ SA ____

Positive prenatal screen, increased nuchal translucency measurement, family history of genetic condition, maternal age >40, ultrasound anomaly

Prenatal referrals should include the following reports (if available):

Blood type, CBC, prenatal screening results, ultrasound(s), antenatal record

Additional information: _____

☐ **General Referral:** Include diagnoses, consult letters and test results, and family history

☐ **Cancer Referral:** Include diagnoses, pathology reports, and family history

Referral requested by: (please print or use stamp)

Name: _____ Billing #: _____

Phone: _____ Fax: _____

Signature: _____ DATE (DD/MM/YYYY): _____