Mackenzie Health
Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

GENETICS CLINIC REFERRAL FORM

Genetics Clinic

Telephone: 905-883-1212 / 905-832-4554 Ext. 7579
Fax: 905-883-2052

Date: _____ (dd/mm/yyyy)

Name: _____

Place Patient Barcode Label Here

***Referrals will only be processed upon receipt of a completed form. Please ensure to include all supporting documents**

Patient Information

Patient Name: *(Last, First)* **Date of Birth:** *(dd/mm/yyyy)*

Main Telephone Number: **Alternate Phone Number:**

Address: *Street or apt#* *City* *Province* *Postal Code* *Country*

Health Card Number: **Version Code:**

Referring Physician

Physician Name: *(Last, First)* **Physician Signature:**

Billing #:

Telephone Number: **Fax:**

Address: *Street or apt#* *City* *Province* *Postal Code* *Country*

Is the patient pregnant? ☐ **No** ☐ **Yes** ***If yes, please fill out Pregnancy details below, and send supporting documents)***

Pregnancy Information

LMP Date: _____ *(dd/mm/yyyy)* Ultrasound Date: _____ *(dd/mm/yyyy)*

Ultrasound CRL Measurement: ☐ cm ☐ mm

Is this a Multiple Pregnancy: ☐ Yes ☐ No If yes, please state:

Reason for Referral

☐ Advance Maternal Age ☐ Increased Nuchal Translucency ☐ Thalassemia ☐ Breast Cancer ☐ Other

☐ Positive Integrated Prenatal Screening / First Trimester Screening / Maternal Serum Screening ☐ Ultrasound Abnormality

Please explain below:

Interpreter required? ☐ **Yes** ☐ **No** **If yes, please specify language:** _____

Supporting Documents Included

☐ Ultrasounds ☐ Specialists Reports ☐ Antenatal Forms ☐ Abnormal Findings ☐ Blood Work

☐ First Trimester Screening / Integrated Prental Sreening / Maternal Serum Sreening Results

PLEASE BE ADVISED: **Our clinic will notify your patient of the appointment details, and all reports will be forwarded to your office. Any positive results will be followed up by our Genetics Team.**

Print Form