MEDICAL GENETICS
Victoria General Hospital
1 Hospital Way, Victoria, BC V8Z 6R5

Tel: (250) 727-4461
Fax: (250) 727-4295
medicalgenetics@islandhealth.ca

GENERAL REFERRAL FORM

PLEASE COMPLETE IN FULL AND PRINT CLEARLY

Instructions: ***Please FAX the completed referral form with all associated medical records (see below) to 250-727-4295.***

Faxing all relevant medical records with this form will enable us to process the referral in a timely manner.

**** The patient and/or referring professional will be notified by the Genetics Clinic of arrangements. ****

PATIENT'S NAME (SURNAME, FIRST, MIDDLE):	OTHER NAME:	DOB: (YY/MM/DD)	DATE OF REFERRAL:

PHN:	MAIDEN NAME:	SEX:	AGE:	ETHNIC ORIGIN:

ADDRESS:	HOME PHONE #:	CELL PHONE #:

CITY:	POSTAL CODE:	EMAIL:	ALTERNATE PHONE #:

MOTHER'S NAME (SURNAME, FIRST, MIDDLE):	MOTHER'S MAIDEN NAME:	DOB :(YY/MM/DD)

FATHER'S NAME (SURNAME, FIRST, MIDDLE):	DOB :(YY/MM/DD)

PARTNER'S NAME (SURNAME, FIRST, MIDDLE):	DOB :(YY/MM/DD)

HAS THIS FAMILY PREVIOUSLY BEEN SEEN IN MEDICAL GENETICS? ☐ No ☐ Yes → Name of Relative, diagnosis and Program/City where seen?

PLEASE SUPPLY NAMES AND BIRTHDATES OF OTHER AFFECTED FAMILY MEMBERS (IF APPLICABLE):

PROVIDE RELEVANT RECORDS WITH A COMPLETED RELEASE OF INFORMATION CONSENT FORM FOR AFFECTED FAMILY MEMBERS. IF A COMPLETE ROI WILL NOT BE ABLE TO BE OBTAINED PLEASE LET OUR OFFICE KNOW.

IS THIS REFERRAL RELATED TO A HEREDITARY CANCER SYNDROME? ☐ No ☐ Yes → Please refer your patient to the Hereditary Cancer Program

IS THIS REFERRAL RELATED TO AN ONGOING PREGNANCY? ☐ No ☐ Yes → Please contact us to obtain a Prenatal Referral Form

IS THIS REFERRAL URGENT? (needs to be seen within 2 – 3 months) ☐ Yes → Reason for urgency?

REASON FOR REFERRAL - PLEASE PROVIDE DETAILS TO ENSURE PROMPT AND APPROPRIATE TRIAGE OF THIS REFERRAL

_____

_____

_____

_____

_____

DOES THIS PATIENT REQUIRE AN INTERPRETER? ☐ No ☐ Yes → Which language?

PLEASE ATTACH (if applicable) :

☐ ALL SPECIALIST CONSULTATION LETTERS
☐ ALL IMAGING REPORTS (MRI, CT, ULTRASOUND, X-RAYS)
☐ ALL DEVELOPMENTAL / PSYCHOLOGICAL / EDUCATIONAL ASSESSMENTS
☐ RECENT BLOOD TEST RESULTS
☐ CHROMOSOME OR OTHER MOLECULAR GENETIC TESTING RESULTS
☐ ALL SPECIAL TESTING (AUDIOLOGY, ERG, EMG, EEG, etc)

REFERRING DOCTOR:	ADDRESS (STREET/CITY/POSTAL CODE)	PHONE #:
MSP BILLING #:		FAX #:
FAMILY DOCTOR:	ADDRESS: (STREET/CITY/POSTAL CODE)	PHONE #:
MSP BILLING #:		FAX #:
OTHER DOCTOR(S):		

***** Please keep photocopied form for future referrals. *****

(AUG. 2024)