MEDICAL GENETICS REFERRAL

Mailing Address: Medical Genetics Program
Armstrong 4, 76 Stuart Street
Kingston ON K7L 2V7
Telephone: 613-548-2467
Toll free: 1-800-567-5722 ext.7950
Fax: **613-548-1348**

PATIENT INFORMATION

Name ______________________________

DOB (YYYY/MM/DD) ___________________

OHIP# ______________________________

CR# ________________________________

Telephone ___________________________

Address _____________________________

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REASON FOR REFERRAL

Is this an urgent referral?

☐ Yes Please specify: ______________________

☐ No

IF AVAILABLE, PLEASE INCLUDE THE FOLLOWING:

☐ Relevant medical records for the patient and/or affected relatives

☐ Results of previous testing (e.g. imaging, genetic testing, behavioural analysis, autopsy, etc)

☐ Reports from other specialists involved in this patient's care

☐ Relevant family history information

REFERRING PHYSICIAN INFORMATION

Printed Name ____

Telephone _________________________________ Fax _________________________________

Referring Physician's Signature ______________________ Date (YYYY/MM/DD) ______________

Please fax completed referral form and documentation to: (613) 548-1348