

MEDICAL GENETICS CLINIC Tel: (604) 875-2157
GENERAL REFERRAL FORM Fax: (604) 875-2825
Provincial Medical Genetics Program
B.C. Women's Hospital
Room C234, 4500 Oak Street, Vancouver, BC, V6H 3N1



BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority



If referral concerns a **CURRENT PREGNANCY**, use form: <http://www.bcwomens.ca/health-professionals/refer-a-patient/medical-genetics-pregnancy-assessment>
If patient lives on **VANCOUVER ISLAND**, refer to: <https://www.islandhealth.ca/our-services/medical-genetics-services/medical-genetics-services>
If referral is of an **ADULT (+18) FOR A HEREDITARY CANCER ASSESSMENT**, refer to: http://www.bccancer.bc.ca/coping-and-support-site/Documents/Hereditary%20Cancer%20Program/HCP_Form-ReferralForm.pdf

Date of referral (DD/MM/YY): _____ Affirm patient is aware of referral Language of interpreter if needed _____
Name (Last, First): _____ DOB (DD/MM/YY): _____
Home Address: _____ Email Address: _____ Postal Code: _____
Primary Tel: home cell work _____ Alt Tel: home cell work _____
Contact Person (if not patient) Name: _____ Tel: _____ Relation to patient: _____
Other relevant family member's Name: _____ Tel: _____ Relation to patient: _____

IMPORTANT: REFERRALS WITHOUT A SPECIFIC CLINICAL QUESTION AND REQUIRED RECORDS WILL BE DECLINED.

CLINICAL QUESTION AND RATIONALE FOR CONSULTATION:

SELECT PREDOMINANT CARE NEED: Diagnosis Variant Interpretation Management Family Implications/ Planning

REQUIRED INFORMATION:

ALL patients

- Relevant consultation notes
- Results from completed genetic testing
Circle: Fragile X / Chromosome microarray/
Panel / Whole Exome Sequencing / Other
- Relevant investigations (e.g., imaging)

Referrals about a FAMILY HISTORY

- Diagnosis in family _____
- Describe how affected person(s) are related to your patient _____

Provide relevant records with a completed Release of Information consent form for affected family members:
<http://www.bccchildrens.ca/your-visit-site/Documents/Release%20of%20Information%20Form.pdf>

Referrals for GENETIC CONNECTIVE TISSUE Disease

(including possible **MARFAN** syndrome)

- Echocardiogram
- Ophthalmology consultation notes
- For possible Marfan syndrome referrals, the systemic score (marfan.org/dx)

Referrals regarding NEURODEVELOPMENT

- Completed developmental assessments (including psychoeducational testing, autism assessments, and/or other)

Referrals for VARIANT interpretation support where parental testing has been recommended

- Parental familial variant testing reports, or
- Confirmation that parental testing will not be available

REFERRING DOCTOR: _____	OTHER DOCTOR: _____
BILLING NUMBER: _____	BILLING NUMBER: _____
ADDRESS: _____	ADDRESS: _____
PHONE NUMBER: _____	PHONE NUMBER: _____
FAX NUMBER: _____	FAX NUMBER: _____

In making a referral, referrer maintains responsibility to be available to the patient in the event in-person care is needed.