Algoma
PUBLIC HEALTH
Santé publique Algoma

Website: www.algomapublichealth.com

Genetic Counselling Clinic
PAEDIATRIC Referral Form

Telephone: (705) 942-4646 x3123 • Fax: (705) 759–5789
294 Willow Avenue • Sault Ste. Marie, ON P6B 0A9

Date of Referral: _____ Is family/patient/client aware of referral? Yes ☐ No ☐

Referring Source: _____ Family Doctor or Paediatrician: _____

Name: _____ Phone (home): _____

Street Address: _____ Phone (cell): _____

City/Postal Code: _____ _____ Phone (work/other): _____

Date of Birth: _____ *(month/day/year)* OK to leave message at home ☐ cell ☐ work/other ☐

OHC #: ☐☐☐☐ ☐☐☐ ☐☐☐ Ver: ☐☐

Is Child Ward of CAS? Yes ☐ Name of CAS Worker: _____ Phone: _____

Name of Foster Parent: _____ Phone: _____

Immediate Family Members (names of Parents/Guardians and Siblings):

Name	Relationship	Date of Birth	Age

Has child or any other family member(s) accessed the Genetic Program? Yes ☐ _____ Name(s)

Diagnosis (reason for referral): _____

Please attach pertinent medical records:

Birth Record: Yes ☐ Progress Notes: Yes ☐ Consult Notes: Yes ☐ Psychometric Testing: Yes ☐
Karyotype: Yes ☐ X-Ray Results: Yes ☐ Blood Work: Yes ☐ Other Genetic Testing: _____

FOR OFFICE USE ONLY Patient #: _____

Pedigree #: ☐☐☐☐☐.☐☐☐

Geneticist or Counsellor: _____ Date: _____