Algoma PUBLIC HEALTH
Santé publique Algoma
Website: www.algomapublichealth.com

Genetic Counselling Clinic: GENERAL Referral Form

Telephone: (705) 942-4646 x 3123 • Fax: (705) 759–5789
294 Willow Avenue • Sault Ste. Marie, ON P6B 0A9

Date of Referral: _____ **Referring Physician:** _____ **Family Doctor:** _____

Name: ..... **Date of Birth (yy/mm/dd):** .....

Address: ..... **City / Postal Code:** .....

OHCN#: ..... **Home phone:** .....

Cell: ..... **Work:** ..... **Email:** .....

Next of Kin: ..... **Next of Kin phone:** .....

If paediatric referral:

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

Immediate Family Members (Parents/Guardians/Siblings):

Name	Relationship	Date of Birth	Age

PLEASE NOTE:

- Patients will be contacted by phone OR sent a Family History Questionnaire (FHQ) which will be reviewed by a genetic counsellor.
- **Some referrals may be declined based on referral criteria and review of the patient's medical and family history.**

REASON FOR REFERRAL: .....

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SIGNIFICANT MEDICAL OR FAMILY HISTORY: .....

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Has the patient or other family member(s) accessed the Genetic Program? Yes ☐ *Pls. Name:* .....

Please attach pertinent medical records – blood work, imaging studies, consultation letters, genetic test results, etc.
Developmental delay or autism – Attach microarray (CGH) result.
FASD referrals – Attach psychometric testing report.

Complete for Prenatal Referrals only
LMP: _____ **EDD:** _____ **Attach:** ☐ **Ultrasound reports** ☐ **Antenatals** ☐ **Screening**

FOR OFFICE USE ONLY

Pedigree #: | | | | | | . | | | |

Geneticist or Counsellor: _____ **Date:** _____
_____ _____
_____ _____
_____ _____