PRHC
Peterborough Regional Health Centre

Genetics Program Referral

1 Hospital Drive, Peterborough, ON K9J 7C6

Fax: 705-876-5129 Phone: 705-876-5185

Surname: _____ First Name: _____ Gender: M ☐ F ☐

Date of Birth: (dd/mm/yyyy): ____/____/____ Health Card Number:_____

Parent/Guardian: _____

Home Phone: (____) _____ Bus. Phone: (____) _____

Address: _____ Postal Code:_____

Has the patient been referred to a Genetics Centre before? No ☐ Yes ☐ Where?_____

☐ **Prenatal Genetic Screening:** LMP: (dd/mm/yyyy) ___/___/___ P___ G___ TA___ SA___

Education, and organization of prenatal genetic screening/diagnostic tests *(optimal referral 7-10 weeks gestation)*

Prenatal referrals should include the following reports (if available)

● *Blood type, CBC, dating ultrasound, antenatal record*

☐ **Other Prenatal Referral:** LMP: (dd/mm/yyyy) ___/___/___ P___ G___ TA___ SA___

Positive screen, increased nuchal translucency measurement, family history of genetic condition

Prenatal referrals should include the following reports (if available)

● *Blood type, CBC, prenatal screening results, ultrasound(s), antenatal record*

Additional information: _____

_____

☐ **General Referral:** Include diagnoses, consult letters and test results, and family history

*Note – for adults with intellectual disability, dementia or impaired capacity, Medical POA must be in place.

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☐ **Cancer Referral:** Include diagnoses, pathology reports, and family history

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Referral requested by: (please print or use stamp)

Name: Billing#

Tel: ( ) Fax: ( )

Date: (dd/mm/yyyy) ____/____/____ Signature: _____