Alberta Health Services

Medical Genetics Referral Form

Please note: Incomplete and/or illegible forms may be returned to originating office, resulting in delays to the patient's appointment.

Genetics File #: _____ (office use only)

****If a referral is urgent, phone notification in addition to faxing is recommended.**
**For non-urgent cases the average wait time to see a Genetic Counsellor is approximately three weeks.
**Appointments for Medical Geneticists are triaged based on urgency.

Referral for: (If known, please mark off one or both below)
□ Medical Geneticist (diagnostic service requested)
□ Genetic Counsellor (diagnosis established in patient/family member and education service requested)

Referral Date: 23/03/2002

Patient Name: Loki **Maiden**: _____

Parent/Guardian (if applicable): Parent

DOB (M/D/Y): 28/06/2003 **PHN**: 9349283749 **Gender**: M / F

UAH #: _____ **Other #**: _____

Address: Meddavakkam, Chennai Mobiles Oppt. **PC**: _____

Telephone #: (Home) 234543 (Alternate/Work) _____

Referring Physician: Dr.Pyhcatrist **Tel #**: 234987 **Fax #**: _____

Address: _____ **PC**: _____

Reason for Referral / History: ***Please attach a consult letter, patient summary and any genetic results***

_____

_____

Has the patient been seen previously in the Edmonton Genetics Clinic? **Yes___No___**

Is the patient/guardian aware of referral? **Yes___No___**

Does the patient require an interpreter? **Yes___No___**

Is the patient pregnant? **Yes___No___**
LMP (M/D/Y):_____
Referred to Maternal Fetal Medicine Clinic: Y/N
Pregnancy history/Ultrasound reports/Serum screening enclosed: Y/N

Total Pages sent: _____

_____
Physician Signature

Please return completed form to:

Medical Genetics Clinic
8-53 Medical Sciences Building
University of Alberta
Edmonton AB T6G 2H7
Phone: 780-407-7333 Fax: 780-407-6845