Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

GENETICS CLINIC REFERRAL FORM

Genetics Clinic

Telephone: 905-883-1212 Ext. 7579
Fax: 905-883-2052

***Referrals will only be processed upon receipt of a completed form. Please ensure to include all supporting documents**

Patient Information

(Last, First) *(dd/mm/yyyy)*

Patient Name: **Date of Birth:**

Main Telephone Number: **Alternate Phone Number:**

Street or Apt# *City/Town* *Province* *Postal Code*

Address:

Health Card Number: **Version Code:**

Referral Physician

(Last, First)

Physician Name: **Physician Signature:**

Billing #:

Telephone Number: Fax Number:

Street: *Apt:* *City/Town* *Province* *Postal Code*

Address:

Is the patient pregnant? ☐ **No** ☐ **Yes** ***If yes, please fill out Pregnancy details below, and send supporting documents***

Pregnancy Information

LMP Date: _____ *(dd/mm/yyyy)* Ultrasound Date: _____ (dd/mm/yyyy)

Ultrasound CRL Measurement: ☐ cm ☐ mm

Is this a Multiple Pregnancy: ☐ Yes ☐ No If yes, please state:

Reason for Referral

☐ Advance Maternal Age ☐ Increased Nuchal Translucency ☐ Thalassemia ☐ Breast Cancer ☐ Other
☐ Positive Integrated Prenatal Screening / First Trimester Screening / Maternal Serum Screening ☐ Ultrasound Abnormality

Please explain below:

Interpreter required? ☐ **Yes** ☐ **No** **If yes, please specify language: _____**

Supporting Documents Included

☐ Ultrasounds ☐ Specialists Reports ☐ Antenatal Forms ☐ Abnormal Findings ☐ Blood Work
☐ First Trimester Screening / Integrated Prenatal Screening / Maternal Serum Screening Results

PLEASE BE ADVISED: **Our clinic will notify your patient of the appointment details, and all reports will be forwarded to your office. Appropriate follow-up will be arranged when necessary.**