

# GENETICS & METABOLICS CLINIC

1S, McMaster Site - Hamilton Health Sciences  
1200 Main Street West, Hamilton ON L8S 4J9  
Phone - 905-521-5085 Fax - 905-521-2602



## REFERRAL FORM

REFERRAL DATE: \_\_\_\_\_

PATIENT INFORMATION		REFERRING PHYSICIAN INFORMATION	
PATIENT NAME:		REFERRING PHYSICIAN:	
DOB:	GENDER:	PHYSICIAN SPECIALTY:	
HEALTH CARD:		PHONE:	FAX:
ADDRESS:		ADDRESS:	
PHONE NUMBER:		BILLING NUMBER:	
INTERPRETER NEEDED: <input type="checkbox"/> YES <input type="checkbox"/> NO		FAMILY PHYSICIAN(If Different From Above):	
LANGUAGE:			

PLEASE NOTE: ★ Incomplete/ illegible referral will be returned ★ Some referrals may be declined based on referral criteria

REASON FOR REFERRAL:
<b>PROGRAM:</b> <input type="checkbox"/> GENETICS <input type="checkbox"/> METABOLICS
<b>URGENCY:</b> <input type="checkbox"/> URGENT <input type="checkbox"/> NON-URGENT
Clinical History/Symptoms:
Relevant Family History?
Has a family member been seen in our clinic? Yes/No, IF yes please include family member's DOB and name.
Genetic testing in family member? Yes/No, If yes please specify/attach.

ADDITIONAL INFORMATION (Please check all that apply)	Y	N	DOCUMENTATION REQUESTED (Please send all reports)
1. Is this patient pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	LMP: <input type="checkbox"/> Ultrasound if available
2. Query Marfan Syndrome or Personal history of aortic dilatation or dissection.	<input type="checkbox"/>	<input type="checkbox"/>	<b>REQUIRED:</b> Echocardiogram Ophthalmology/optometry consult
3. History of developmental regression or abnormal brain MRI.	<input type="checkbox"/>	<input type="checkbox"/>	MRI done <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Personal history of developmental delay? Chromosome Microarray done? Fragile X testing done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Microarray report <input type="checkbox"/> Parent testing (arrange/send report) <input type="checkbox"/> Fragile X report
5. Short stature/skeletal concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Skeletal survey

### PLEASE SEE ALTERNATIVE SERVICE FOR:

- Recurrent miscarriage (order karyotype and refer to fertility clinic)
- Malignant Hyperthermia with **NO** known familial mutation (refer to Malignant Hyperthermia clinic)
- Diagnostic work-up for hemophilia (refer to hemophilia clinic)
- Diagnostic work-up for hemochromatosis/iron overload (refer to hematology)
- Pregnant patients for assessment of late maternal age, ultrasound findings, prenatal screening results (refer to prenatal diagnosis clinic)
- Family history of cancer or diagnostic work-up of cancer syndrome (refer to Juravinski cancer clinic)
- Adult assessment for Ehlers Danlos syndrome, hypermobility subtype (refer to EDS clinic at Toronto General Hospital)

**Please fax your referral and all relevant documentation to the Genetics & Metabolics clinic at 905-521-2602**  
1S, 1200 Main Street West, Hamilton, Ontario, L8N 3Z5 Phone: 905-521-5085