

PROVINCIAL MEDICAL GENETICS PROGRAMME

Children's & Women's Health Centre of B.C.
 4500 Oak Street, Room C234, Vancouver, B.C. V6H 3N1
 Telephone: (604) 875-2157

GENERAL REFERRAL FORM INFORMATION SHEET

Is Patient Pregnant?

Yes No

• FAX completed referral form and records to: (604) 875-2825	Your office will be contacted directly once an appointment has been scheduled.
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Patient Information: (Please Print Clearly):

PATIENT'S SURNAME:	GIVEN NAME:	MIDDLE NAME:	DOB: (YY/MM/DD)	MEDICAL GENETICS#:
PHN:	MAIDEN NAME:	AGE:	ETHNIC ORIGIN:	CHILDREN'S HOSP #
ADDRESS (STREET/CITY/POSTAL CODE):		HOME PHONE #:	WORK PHONE #:	WOMEN'S HOSP #
			ALTERNATE PHONE #:	

MOTHER'S SURNAME _____	GIVEN NAME	DOB (YY/MM/DD)	ETHNIC ORIGIN
PHN#			
FATHER'S SURNAME _____	GIVEN NAME	DOB (YY/MM/DD)	ETHNIC ORIGIN
PHN#			
PARTNER'S SURNAME _____	GIVEN NAME	DOB (YY/MM/DD)	ETHNIC ORIGIN
PHN#			

REFERRING DOCTOR:	ADDRESS (STREET/CITY/POSTAL CODE)	PHONE #:
BILLING #:		FAX #:
FAMILY DOCTOR:	ADDRESS: (STREET/CITY/POSTAL CODE)	PHONE #:
BILLING #:		FAX #:

OTHER DOCTOR(S): _____

REASON FOR REFERRAL AND RELEVANT CLINICAL HISTORY: _____

Please supply names and birthdates of other affected family members. Please attach any relevant records (eg. Other consultations, previous investigations, psychoeducation assessments, ...etc.)