Maritime Medical Genetics Service – NON-CANCER REFERRAL

(Physician use ONLY)

Website https://iwkhealth.ca/clinics-programs-services/maritime-medical-genetics-service

FAX #: (902) 470-8709 **Phone #: (902) 470-8754**

FAX this referral **INCLUDING all relevant test results and consultation letters** to ensure patient is triaged appropriately.

PATIENT INFORMATION

Patient's Name _____
First Middle Last

Date of Birth (d/m/y) _____ Gender: ☐ Male ☐ Female ☐ Other _____

Language Preferred: ☐ English ☐ French ☐ Other _____

COMPLETE Mailing Address _____
Street / PO Box

-- Select Province --
Town/City Province **Postal Code**

Phone # (Home) _____ (Other) _____ Health Card # _____ Exp _____

If child: Parents Names _____ or Guardian (name/relationship): _____

If pregnant: LMP: _____ **EDC:** _____ **G** ☐ **P** ☐ **SA** ☐ **TA** ☐ **Ultrasound Date:** _____
(d/m/y) (d/m/y) (d/m/y)

REASON FOR REFERRAL: _____

_____

_____

_____

REFERRING PHYSICIAN INFORMATION

Physician name (please **PRINT**): _____ Phone: _____
First Last

Mailing Address: _____
Facility Street / PO Box

-- Select Province --
Town/City Province Postal Code

FAMILY PHYSICIAN NAME (please **PRINT**) _____
First Last

Updated: September 16, 2016