Trillium Health Partners

CLINICAL GENETICS REFERRAL FORM

2200 Eglinton Ave W, Mississauga, ON L5M 2N1
Phone Number: 905-813-4104 Fax Number: 905-813-4347

- The referral will be processed more efficiently if all relevant medical records are included.
- Incomplete or illegible referrals will be returned to your office.
- Some referrals might be declined based on referral criteria.
- **Your patient will be contacted directly with an appointment. We also will notify your office.**

REFERRING HEALTH CARE PROVIDER

Name: _____ Billing Number: _____

Address: _____

Phone Number: _____ Fax Number: _____

REFERRAL REASON

☐ **PRENATAL see below*** ☐ **NEUROGENETICS** ☐ **CARDIOGENETICS**

☐ **HEREDITARY CANCER** ☐ **DEVELOPMENTAL DELAY** ☐ **OTHER**

☐ **FAMILY HISTORY OF:** _____

REASON FOR REFERRAL:

please include any relevant medical reports and/or test results for the patient and/or their affected family members

*** PRENATAL REFERRALS ONLY*

Last Menstrual Period date: _____

Please include all of the following information for the current pregnancy with the referral

- all ultrasounds
- antenatal records 1 & 2
- prenatal screening result
- blood group and screen
- CBC and hemoglobin electrophoresis
- Infection screening

Please fax this completed form to Clinical Genetics at 905-813-4347

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