

Your patient will be contacted within 10 business days of receiving the referral. They will receive instructions on booking an appointment by telephone/email/text. If there are any changes to your patient's demographic information, please inform us as soon as possible at: genetics@dynacare.ca.

Your patient consents to receive communication by email. Referral Date (MM/DD/YYYY): _____

Patient information

Last Name: _____

First Name: _____

DOB (MM/DD/YYYY): _____

Health Coverage Pro#: _____

Telephone# (Mobile Preferred): _____

Address: _____

Email address: _____

Biological Sex at birth: ____ Gender Identity: _____

Physician/healthcare provider information

Name: _____

Telephone#: _____

Fax#: _____

Billing#: _____

Address: _____

Healthcare provider email address: _____

Healthcare provider signature: _____

Interpreter required: Yes No Language: _____

Reason for referral (Please check all that apply):

Personal Diagnosis of: _____

Condition has been confirmed by genetic testing? Yes No

If Yes, Gene: _____ Variant/Mutation: _____

Variant/Mutation identified in family member [please attach report(s)].

Gene: _____ Variant/Mutation: _____

Concern about a personal/ family history of: _____ (Name of Condition)

Other (Please describe): _____

Please attach any clinical notes, family history information and familial variant/mutation results if known.