

Your patient will be contacted within **10** business days of receiving the referral. They will receive instructions on booking an appointment by telephone/email. 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): _____

Patients information	Partner 1	Partner 2 (if necessary)
Patient Name		
DOB (MM/DD/YYYY)		
Biological Sex at Birth (M/F/Other)		
Gender Identity (M/F/Non-Binary/Other)		
Health Card Number		
Address		
Postal Code		
Phone (Mobile preferred) & Email		
Type of hemoglobinopathy:	<input type="checkbox"/> Alpha-thalassemia <input type="checkbox"/> Beta-thalassemia <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Alpha-thalassemia <input type="checkbox"/> Beta-thalassemia <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Other (specify): _____
Ethnic background:		

Interpreter required: Yes No Language: _____

Required with Every Referral (both partners if applicable)	Reason for Referral
<ul style="list-style-type: none"> • Standard test results: <ul style="list-style-type: none"> • CBC • Ferritin • Hemoglobin electrophoresis • Prenatal ultrasound(s) (if available) <p>Has Genetic Testing been ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> • If yes, please attach copies of the reports 	<input type="checkbox"/> Carrier status <input type="checkbox"/> Preconception counselling <input type="checkbox"/> Prenatal counselling <input type="checkbox"/> Affected <input type="checkbox"/> Other (Specify): _____
<p>Pregnancy Information</p> <p>GRAVIDA: _____</p> <p>PARA: _____</p> <p>LMP YYYY/MM/DD: _____</p> <p>EDD YYYY/MM/DD: _____</p>	<p>Referring Physician/Healthcare Provider</p> <p>Referring physician: _____</p> <p>Genetic counsellor/other: _____</p> <p>Street address: _____</p> <p>City: _____</p> <p>Postal code: _____</p> <p>Telephone: _____</p> <p>Fax: _____</p> <p>Email: _____</p> <p>Billing#: _____</p> <p>Physician/Healthcare provider signature: _____</p>