Dynacare®
Genetics and Specialty Services

PGx Referral Form

Please fax referral to 450-901-3076

Your patient will be contacted within 10 business days of receiving the referral. They will receive instructions onbooking 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#: ____________

Address: ____________

Healthcare provider email address:

____

Billing#: ____________

Healthcare provider signature:

____

Interpreter required: ☐ Yes ☐ No   Language: ____________

Reason for referral (Please check all that apply):

☐ *UGT1A1 variant* **c.211G>A** found on initial PGx test

☐ *POLG variant* **c.1399G>A** found on initial PGx test

☐ *POLG variant* **c.2243G>C** found on initial PGx test

☐ *MT-RNR1 variant* **c.1555A>G** found on initial PGx test

Personal and/or family history of cancer (please check all that apply)

☐ Seizures

☐ Migraine

☐ Stroke

☐ Hearing Loss

☐ Hypotonia/Muscle weakness

☐ Cataract

☐ Eye muscle paralysis

☐ Liver dysfunction/failure

☐ Testicular/ovarian failure

☐ Other: ____________