Dynacare®
Genetics and Specialty Services

Dynacare – Preconception 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 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.

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		

Interpreter required: ☐ Yes ☐ No Language: ______________________

Referring doctor/health care provider: ______________________

Clinic address/Phone/Fax ______________________

Billing#: ______________________ Email: ______________________

Reason for referral

☐ Patient or partner with previous pregnancy affected by birth defect or other genetic condition

☐ Personal and/or Family History of known condition:

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Name of affected person: ______________________

Relationship to patient: ______________________

DOB (MM/DD/YYYY): ______________________

☐ Positive carrier screening for one or both partners (following carrier screening)
Please indicate conditions for each partner:
Partner 1: ______________________
Partner 2: ______________________

☐ Consanguinity

☐ Other: ______________________

Additional relevant clinical and/or family history:

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