Dynacare®

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Hemoglobinopathy Genetic Counselling Referral Form

Your patient will be contacted within 14 business days of receiving the referral. They will receive instructions on booking an appointment by telephone/email. A family history questionnaire will be provided to the patient and must be completed prior to their appointment. 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.
Email address: _____

Date of Referral YYYY/MM/DD: _____

Patient Information	Partner 1	Partner 2 (if applicable)
Last name:		
Legal first name:		
Preferred name:		
Date of birth YYYY/MM/DD:		
Biological sex at birth:	☐ M ☐ F ☐ Other	☐ M ☐ F ☐ Other
Gender identity:	☐ M ☐ F ☐ Non-binary ☐ Other	☐ M ☐ F ☐ Non-binary ☐ Other
Health card #:		
Street address:		
City:		
Postal code:		
Telephone:		
Type of hemoglobinopathy:	☐ Alpha-thalassemia ☐ Beta-thalassemia ☐ Sickle cell anemia ☐ Other (specify):	☐ Alpha-thalassemia ☐ Beta-thalassemia ☐ Sickle cell anemia ☐ Other (specify):
Ethnic background:		

Required with Every Referral (both partners if applicable)

- **Standard test results:**
  - CBC
  - Ferritin
  - Hemoglobin electrophoresis
- **Prenatal ultrasound(s)** (if available)

Has Genetic Testing been ordered? ☐ **Yes** ☐ **No**

- **If yes, please attach copies of the reports**

Pregnancy Information

GRAVIDA: _____

PARA: _____

LMP YYYY/MM/DD: _____

EDD YYYY/MM/DD: _____

Reason for Referral

☐ **Carrier status** ☐ **Affected**
☐ **Preconception counselling** ☐ **Prenatal counselling**
☐ **Other** (specify): _____

Referring Physician/Healthcare Provider

Referring physician: _____

Genetic counsellor/other: _____

Street address: _____

City: _____ Postal code: _____

Telephone: _____

Fax: _____

Email: _____

Interpreter required: ☐ **Yes** ☐ **No**

Language: _____

Physician/Healthcare provider signature: _____