Dynacare®

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PGx 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: _____

Referral Date MM/DD/YYYY: _____

Patient Information

Last Name: _____
First Name: _____
DOB (MM/DD/YYYY): _____
Health Coverage information #: _____
Telephone #: _____
Address: _____
Email Address: _____
Phone: _____

Physician/Healthcare Provider Information

Name: _____
Telephone #: _____
Fax #: _____
Address: _____
Healthcare Provider Email Address: _____
Healthcare Provider Signature: _____

Interpreter required: ☐ Yes ☐ No Language: _____

Reason for Referral

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

Indicate if your patient has a personal or family history of any of the following:

- ☐ Seizures
- ☐ Migraine
- ☐ Stroke
- ☐ Hearing Loss
- ☐ Hypotonia/Muscle weakness
- ☐ Cataract
- ☐ Eye muscle paralysis
- ☐ Liver dysfunction/failure
- ☐ Testicular/ovarian failure
- ☐ Other: _____