|  |  |  |  |
| --- | --- | --- | --- |
| **Genetic Health Service Referral Form**  Incomplete or illegible forms will delay patient care.  Please complete fully, and electronically when possible. | | | |
| **Patient Details** (affix sticker/complete)  Name: DOB:  NHI:  Address:  Phone:  Email: | | **Referrer/GP details**  Referrer name (if not GP):  Service:  Contact:  GP name:  GP Clinic: | |
| **Has a relative previously been seen at genetic clinic?** Yes / No  If Yes, name of that relative:  Relationship to patient:  Clinic/hospital/country where relative was assessed: | | | |
| **Referral Category** | | | |
| **Adult ☐** | **Paediatric ☐** | **Prenatal ☐** | **Family planning ☐** |
| ☐Diagnostic test  ☐Predictive test (testing for known genetic condition in family) | ☐Inpatient  ☐Outpatient | LMP:  Gestation:  Ultrasound report attached: Yes/No  **Partners name:**  **Partners NHI:** | **Partners name:**  **Partners NHI:** |
| **Relevant information** | | | |
| **Reason for referral:** | | | |
| **Relevant history:** Please provide names / DOBs / NHIs of relevant affected individuals/family members, including how they are related to the proband / age of symptom onset. Please also include all relevant information for the case: ☐ **genetic testing reports** ☐ **scans** ☐ **post-mortem reports** | | | |
| **Other:** Please include other relevant information including if an interpreter is needed, if there is consanguinity, or if your patient has a limited lifespan (we may contact you or your patient to arrange DNA storage).  *Please include any details about clinical urgency or treatment impact, including dates of expected treatment. Please note we have limited ability to prioritise new referrals and are limited by our capacity.* | | | |

☐ Patient is aware of this referral and has provided consent