# OUTPATIENT REFERRAL TO GENETICS

REF-GEN

*Following receipt of referral, a family history questionnaire will be sent to your patient unless their family has already been seen or if this is an inpatient consultation or urgent referral.*
*Depending on the reason for referral, a completed family history form may be required for further assessment.*
*Genetic testing may or may not be offered depending on your patient's eligibility and/or the availability of testing.*
*To inquire about a referral, contact us at (709) 777-4363. Wait-times can be significant. Please notify us if your patient's condition changes.*

## FAMILY HISTORY

**Has a family member previously been seen by Medical Genetics?** ☐ Yes ☐ No

If Yes:

Name of relative seen: _____

Relationship: _____

Location seen (province, country): _____

Pedigree (PED) number: _____

*Please send the genetic report and/or genetic counselling letter if available.*

## REFERRAL CATEGORY

**What is the referral category?** ☐ Prenatal ☐ Cancer ☐ Cardiac ☐ General Genetics

### If PRENATAL Selected

**Has this patient had MSS or NIPT?** ☐ Yes ☐ No

If Yes — please provide results if not in Corcare: _____

**Reason for referral to prenatal genetics:**

☐ Abnormal ultrasound finding ☐ Personal or family history of genetic condition or congenital anomaly ☐ Teratogen exposure

☐ Other

Provide details of the history: _____

_____

Please enter relative(s) name: _____

How is your patient related to the individual(s)?: _____

## If CANCER Selected

**Personal history of cancer?** ☐ Yes ☐ No

If Yes:

Type of cancer: _____

Age at diagnosis: _____

**Genetic result required for treatment?** ☐ Yes ☐ No

If Yes — Please specify the timeline for treatment: _____

**Has had previous genetic testing or IHC/MSI (dMMR) tumour screening?**

☐ Yes ☐ No

If Yes — Please provide details or are results in Corcare? _____

**Is there a known familial genetic variant in a cancer predisposition gene?**

☐ Yes ☐ No

If Yes:

How is your patient related to the individual(s)?: _____

Please enter relative(s) name: _____

Please enter comments: _____

## If CARDIAC Selected

**Reason for referral:**

☐ Arrhythmia ☐ Cardiomyopathy ☐ Hypercholesterolemia ☐ Other ☐ Family history of the previous options

If Arrhythmia / Cardiomyopathy / Hypercholesterolemia / Other selected:

Please specify: _____

If Family history of the previous options selected:

Provide details of the history: _____

How is your patient related to the individual(s)?: _____

Please enter relative(s) name: _____

**Previously seen by cardiology?** ☐ Yes ☐ No

**Current clinical status:** ☐ Asymptomatic ☐ Symptomatic

## If GENERAL GENETICS Selected

**Reason for referral:**

☐ Developmental delay / intellectual disability ☐ Congenital anomaly / dysmorphic features ☐ Known or suspected genetic condition

☐ Family history of genetic condition ☐ Other

Additional relevant information (if applicable): _____

## REFERRAL TYPE & COMMENTS

**Referral Type:** ☐ New Referral ☐ Update to Existing Referral

Comments: _____