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| **Template: Patient referral form**Assessment for clinical genetics or genomics services | **<Name of outpatient clinic>**<Address of clinic><Phone, fax and email of clinic> |

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| *Outpatient clinic use only* |  | **Referral to:** |
| Referral received: | / / |  |
| Referrer notified of receipt: | / / |  |

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| **Patient or client details**  |
| Patient name: | Address: |
|  |
| Title: | Mr  Mrs  Ms  Miss  |  |
| Medicare number: |  | Date of birth: | / / |
| Sex/gender: | **M** (male)  **F** (female)  **X** (indeterminate/intersex/unspecified)  |
| Phone: | W (work) H (home) M (mobile) |
| Email: |  | Communication preference:Phone W  Phone H  Phone M  Email  |
| Carer name (if appropriate): | Phone: |  |
| Email: |  |
| Identifies as of Aboriginal or Torres Strait Islander origin: | Yes  | No  | Interpreter required: | Yes  | No  |
| Language: |
| Special needs/reasonable adjustmentsrequired for disability: | Yes  | No  | Description of required adjustments: |
| GP name (if not referrer): | Phone: |  |
| Email: |  |

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| **Clinical details**  |
| Reason for referral:  |
| Urgent referral (please call on-call geneticist on *<insert number>* | Yes  | **** Results of this consultation required for urgent medical management decisions  | No  |
| **** Children under the age of 6 months |
| **** Pregnant patient |
| Pregnancy Concern: | Yes  | Last menstrual period (LMP)/estimated date of delivery (EDD):  | No  |
| **** Increased risk prenatal screening result (include copies of all results) |
| **** Patient and/or partner affected by inherited condition **** Family history of an inherited condition **** Foetal abnormality suggestive of an underlying genetic disorder |
| Preconception Concern: | Yes  | **** Personal and/or family history of a genetic or chromosomal condition | No  |
| **** Personal and/or family history of stillbirth or recurrent miscarriage |
| **** Thalassaemia concern (include patient & partner FBC, HbEPG and Iron Studies) |
| Personal history genetic condition: | Yes  | **** Rare genetic or chromosomal diagnosis | No  |
| **** Congenital anomalies and/or significant developmental delay (e.g. mild intellectual disability) |
| Family history genetic condition: | Yes  | **** Hereditary condition in the family. Please describe on other page and provide reports relevant to the diagnosis | No  |
| **** Family history of intellectual disability and/or congenital anomalies |
| **** Consanguinity and family history of hereditary condition |
| *To be completed by Clinical Genetics Service ONLY* |
|  Urgent  Non-Urgent Cat 1 (within 30 days)  Non-Urgent Cat 2 (within 90 days)  Non-Urgent Cat 3 (within 365 days) |

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| **Referrer details** |
| Name: | Paediatrician  Other specialist  GP  |
| Provider #: |  | Phone: |  |
| Email: |  | Fax: |  |
| Signature: |  | Date: / / |

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| Other clinical details if required: |
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| Please send this form to: |
| Please fax or email to *<insert name of clinical genetic service>* on (02) *<phone>* or *<email>*If this is an urgent referral, please call on-call clinical geneticist via the main hospital switch on *<insert number>*. |

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