**Northeastern Ontario Medical Genetics Program**
Sudbury Outpatient Centre, Health Sciences North
865 Regent Street South – Sudbury, ON P3E 3Y9
Tel: (705) 675-4786 | Fax: (705) 523-7178
www.hsnsudbury.ca/genetics

ADDRESSOGRAPH

# REQUEST FOR GENETICS CONSULTATION

PLEASE PRINT CLEARLY. FORWARD THE COMPLETED FORM TO THE NORTHEASTERN ONTARIO MEDICAL GENETICS PROGRAM VIA FAX.

** If the indication for referral is a personal and/or family history of CANCER, please use the "Request for CANCER Genetics Consultation" form, which can be found on our website.*

**PATIENT DEMOGRAPHIC INFORMATION** Date of Birth: YYYY / MM / DD OHIP#: _____

Last Name: _____ First Name: _____ Other/Preferred: _____

Sex Assigned at Birth: □ Male □ Female □ Unknown/Specify: _____ Gender Identity: _____

Address: _____ Pronouns: _____

City: _____ Postal Code: _____ Email: _____

Telephone (Preferred): _____ Telephone (□ Alternative / □ Contact Person): _____

Contact person name/relationship to patient (if applicable): _____

Preferred Language: □ English □ French □ Other (specify): _____ Patient aware of referral? □ Yes □ No

THE FOLLOWING MEDICAL INFORMATION IS **REQUIRED** IN ORDER FOR US TO PROCESS THE REFERRAL. Please complete all sections below, and ensure to attach all requested relevant medical documentation with your referral (i.e. consultation notes, genetic test reports, etc.).

**1) IS THIS REFERRAL URGENT (I.E. RESULTS OF ASSESSMENT WILL ALTER IMMEDIATE CLINICAL MANAGEMENT)? □ YES □ NO**
**IF YES, SPECIFY THE REASON (REQUIRED): □ PRENATAL* □ NEONATAL □ END OF LIFE □ OTHER:** _____
_____
** Prenatal Referrals: If this request is related to a current pregnancy, please include the following documentation (required):*
*□ LMP: YYYY / MM / DD □ All ultrasound reports □ Antenatal records □ Prenatal screening reports (i.e. MMS, NIPT) □ Blood group/CBC*

**2) REASON FOR REFERRAL / NAME OF CONDITION(S) PROMPTING REFERRAL:** _____
_____

□ **THIS PATIENT HAS A □ CONFIRMED / □ SUSPECTED (SELECT ONE) DIAGNOSIS OF THE CONDITION(S) LISTED ABOVE.**
If yes, list all pertinent medical history/positive physical findings, and/or include relevant medical documentation (i.e. consultation notes, developmental assessments, medical imaging reports, genetic test reports, etc.): _____
_____
_____

□ **THIS PATIENT HAS FAMILY HISTORY OF THE CONDITION(S) LISTED ABOVE. PLEASE ALSO ANSWER QUESTION 3.**
If yes, complete the table below and include all known details (required).

| RELATIONSHIP TO THIS PATIENT (e.g. paternal aunt, maternal uncle, etc.) | MEDICAL CONDITION / DIAGNOSIS |
|---|---|
| | |
| | |
| | |

**3) IS THIS PATIENT ADOPTED? □ YES □ NO IF YES, IS BIOLOGICAL FAMILY HISTORY INFORMATION AVAILABLE? □ YES □ NO**

**4) ARE THERE ANY INVESTIGATIONS PENDING FOR THIS PATIENT AND/OR RELATIVE(S) RELATED TO REASON FOR REFERRAL? □ YES □ NO**
If yes, please specify, and send copies of any reports, once available: _____
_____

**5) HAS A CLINICALLY SIGNIFICANT VARIANT BEEN IDENTIFIED IN THIS PATIENT AND/OR THEIR RELATIVE(S)? □ YES □ NO**
**IF YES, INCLUDE A COPY OF THE GENETIC TEST REPORT(S) FROM THE GENETIC TESTING LABORATORY (REQUIRED).**
If the genetic test report is for a relative, specify how this individual is related to your patient: _____

**6) HAS THIS PATIENT BEEN SEEN IN A GENETICS CLINIC PREVIOUSLY? □ YES □ NO**
**IF YES, SPECIFY LOCATION AND PROVIDE COPIES OF ANY DOCUMENTS RELATED TO THE CONSULTATION(S) (REQUIRED).**

**7) IS THERE ANY RELEVANT INFORMATION REGARDING ANY ACCOMODATIONS THAT CAN BE MADE TO BETTER SERVE THIS PATIENT (I.E. DISABILITY, HEARING/VISION LOSS, SPECIFIC SOCIAL SITUATION, INCREASED RISK FOR FALLS, ETC.)?** _____
_____

**REFERRING HEALTH CARE PROVIDER*:** Provider #: _____

Name: _____ Address: _____

Telephone: _____ _____

Fax: _____ Signature: _____

**REFERRAL CHECKLIST**:
□ Completed Genetics Requisition Form
□ Consult Notes, Imaging Reports, etc.
□ Genetic test report(s), if applicable.

** Please ensure all demographic information is completed in full, including the full name of the referring health care provider, as well as the fax number, in order to ensure that our communication reaches you. We will respond to all referral requests and confirm our triage decision via fax within two weeks.*

Health Sciences North
Horizon Santé-Nord

**Northeastern Ontario Medical Genetics Program**
**Sudbury Outpatient Centre, Health Sciences North**
Tel: (705) 675-4786 | Fax: (705) 523-7178

## HOW TO MAKE A REFERRAL AND TRIAGE PROCESS

- Please complete the "Request for Genetics Consultation" form, and forward the completed form to the Northeastern Ontario Medical Genetics Program via fax to (705) 523-7178.
- If the indication for the referral is related to a personal and/or family history of cancer, please use the "Request for CANCER Genetics Consultation" form, which can be found on our website at www.hsnsudbury.ca/genetics.
- We will respond to all referral requests and confirm our triage decision via fax within two weeks. Some referrals will be declined, and an explanation for the decline will be provided. Information to share with the patient and guidance for the referring health care provider will be provided, where appropriate.

## IMPORTANT INFORMATION TO COMPLETE WITH YOUR REFERRAL

- Please complete the patient demographic section in full.
- All known relevant medical and/or family history should be included.
  - This includes medical documentation such as consultation notes, medical imaging reports, developmental assessments, genetic test reports, etc.
  - For prenatal referrals, please include all ultrasound reports, antenatal records, prenatal screening reports (i.e. MMS, NIPT), as well as blood group and CBC.
- If a clinically significant variant has been identified in your patient's family, a copy of the affected relative's genetic test report (i.e. from the genetic testing laboratory) is required.
  - Please note that without this medical documentation, the referral will be declined due to lack of supporting medical documentation. This documentation is required to determine your patient's eligibility for genetic testing and provide them with the most accurate risk assessment.
- Complete the referring health care provider section in full, including full name and fax number.

## COMMON EXAMPLES OF APPROPRIATE REFERRAL INDICATIONS

The Northeastern Ontario Medical Genetics Program provides assessment, diagnosis and genetic counselling for individuals with a confirmed or suspected diagnosis of a genetic condition, or a family history of the same. The following list provides common examples or appropriate referral types, but is not exhaustive:

- Individuals with a known or suspected genetic condition, including, but not limited to skeletal dysplasias, cardiogenetic disorders, connective tissue disorders, neurogenetic disorders, oculogenetic disorders, etc.;
- Individuals with congenital malformations with a suspected genetic etiology;
- Individuals with developmental delay, intellectual disability and/or autism with syndromic features (e.g. dysmorphic features, congenital anomalies, etc.);
- Individuals with a personal and/or family history of a genetic condition (e.g. muscular dystrophy, cystic fibrosis, osteogenesis imperfecta, Huntington disease, etc.);
- Individuals with a personal and/or family history of a chromosome abnormality (e.g. Trisomy 21, chromosomal rearrangement, copy number variant(s), etc.);
- Individuals with an increased risk of aneuploidy or chromosome abnormality in the context of a pregnancy (e.g. NIPT result consistent with "High Risk" for aneuploidy, increased nuchal translucency, etc.);
- Individuals with a personal and/or family history of cancer suggestive of a hereditary cancer syndrome.
  - For this referral indication, please use the "Request for CANCER Genetics Consultation" form, which can be found on our website at www.hsnsudbury.ca/genetics).

## CONTACT US

- If you have any questions about the above information, or if you have questions regarding the appropriateness of a referral, please contact us at (705) 675-4786.