





Facility: COM HKH MQE MVH RNS RYD

# REFERRAL - CLINICAL GENETICS

FAMILY NAME		MRN
GIVEN NAME		MALE FEMALE
D.O.B. DD / MM / YYYY	M.O.	
ADDRESS		
		PH
M/C	FIN	
LOCATION / WARD		ADM DD / MM / YYYY

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

<b>Preconception concern:</b>	Yes	No	
Personal and/or family history of a genetic or chromosomal condition			
Personal and/or family history of stillbirth, or recurrent miscarriage <b>and</b> conventional karyotype in one partner shows a chromosomal abnormality.			
Thalassaemia concern (include patient & partner FBC, HbEPG and iron studies)			
<b>Personal history genetic condition:</b>	Yes	No	
Rare genetic or chromosomal diagnosis			
Congenital anomalies and/or significant developmental delay e.g. at least moderate development delay.			
<b>Family history genetic condition:</b>	Yes	No	
Please describe below and provide reports relevant to the diagnosis, if available:			
<b>Clinical details: (required information)</b>			
<b>Please clearly indicate if this referral relates to a current pregnancy</b>			
<b>Note:</b> referrals for children will only be accepted from paediatricians)			
<b>Reason for referral:</b>			
<b>Relevant personal and/or family history (please attach relevant results):</b>			
<b>Has the patient/family been seen by another genetics service?</b>			
If yes, please provide details:			
<b>To be completed by Clinical Genetics Service only:</b>			
Urgent	Non-Urgent Cat 1 (within 30 days)	Non-Urgent Cat 2 (within 90 days)	Non-Urgent Cat 3 (within 365 days)
<b>Please send this form and relevant reports via fax or email to:</b>			
Royal North Shore Hospital, Clinical Genetics on fax (02) 9463 1057 or nslhd-clinicalgenetics@health.nsw.gov.au			
If this is an urgent referral, please call the on-call clinical geneticist on 02 9463 1727.			

Notes punched as per AS2828.1:2019  
**BINDING MARGIN - NO WRITING**