This PDF will expire on 1 October 2023

LOCATION / WARD

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

Facility: COM HKH MQE MVH RNS RYD

## REFERRAL - CLINICAL GENETICS

	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL F	HER
1		

Referral to: Clinical Associate Professor Yemima Berman, RNSH	Referral received://					
	Referrer notified of receipt:/					
Patient or Client Details						
Name	. Title	Sex a	ssigned at birth .			
Address						
Medicare number	Date of birth:	//_				
Phone Email						
Carer name (if appropriate)						
Phone Email						
Are you of Aboriginal or Torres Strait Islander Origin?	Yes – Aboriginal Yes – both		Yes – Torres Strait Islander Neither Unknown		vn	
Interpreter required:	Yes	No				
Language						
Special needs/reasonable adjustments required for disability:	Yes	No				
Description of required adjustments						
GP name (if not referrer)						
Phone Email						
Referrer details						
Name		Paedia	ntrician GP	Other s	specialist	
Provider No.	_ Fax				<u>.</u>	
Phone Email						
Signature	Date:/_	/				
Clinical details overview						
Reason for referral: (referrals with inadequate detail may be retu	ırned).					
Urgent referral (please call on-call geneticist on 02 9463 1727)				Yes	No	
Results of this consultation required for urgent medica	l management	decisions				
Children under the age of 6 months						
Pregnant patient						
Pregnancy concern (please call on-call genetic counsellor on 02 9	9463 1727)			Yes	No	
Last menstrual period (LMP)/estimated date of delivery (EI	DD)			·		
Increased risk prenatal diagnostic result (i.e CVS or amnio). Include copies of all results. If high risk NIPT/combined first trimester screening, please contact the Maternal Fetal Medicine Unit, RNSH (Ph: 9463 2370).  Patient and/or partner affected by inherited condition  Family history of an inherited condition						

CATALOGUE NUMBER CC12746 SEP22/V1

Fetal abnormality suggestive of an underlying genetic disorder



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## **REFERRAL-CLINICAL GENETICS**

EMALE	
ADM DD / MM / YYYY	

COMPLETE ALL DETAILS OR	AFFIX PATIENT LABEL HEF	RE
Preconception concern:	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 in one partner shows a chromosomal abnormality.	karyotype	
Thalassaemia concern (include patient & partner FBC, HbEPG and iron studies)		
Personal history genetic condition:	Yes	No
Rare genetic or chromosomal diagnosis		
Congenital anomalies and/or significant developmental delay e.g. at least moderate d	evelopment delay.	
Family history genetic condition: Please describe below and provide reports relevant to the diagnosis, if available:	Yes	No
Clinical details: (required information)		
Please clearly indicate if this referral relates to a current pregnancy Note: referrals for children will only be accepted from paediatricians) Reason for referral:		
Relevant personal and/or family history (please attach relevant results):		
Has the patient/family been seen by another genetics service? If yes, please provide details:	Yes	No
To be completed by Clinical Genetics Service only:		
	Non-Urgent Cat 3 (within 3	365 days)
The state of the s		

Please send this form and relevant reports via fax or email to:

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.