GENETICS REFERRAL FORM

Email: genetics@austin.org.au **Telephone: (03) 9496 3027** **Fax: (03) 9496 4385**

REFERRAL SOURCE				**CLIENT DETAILS**			
Doctor				**Name**			
Address				**Address**			
				Email			
Fax				**Phone**			
Email				**Date of Birth**			
Provider No.				**Gender**			
Signature				**Medicare No.**			
Referral date		**Duration**	☐ 3 months	☐ 12 months	☐ indefinite		

UNIT REQUIRED	**Clinical Genetics**	**HEAD OF UNIT**	**Dr Ainsley CAMPBELL**
Clinical urgency:	☐ Urgent	☐ Routine	☐ Pregnant
If urgent, please phone and discuss with the duty Genetic Counsellor on 03 9496 3027			

REASON FOR REFERRAL

Past Medical History and Family History

Relevant medications

☐ Relevant investigations and correspondence attached

Has the patient consented to provide the above-mentioned information?	Yes ☐	No ☐

CLIENT INFORMATION					
Is patient Aboriginal	Yes ☐	No ☐	Is the patient a veteran?	Yes ☐	No ☐
Is patient Torres Strait Islander?	Yes ☐	No ☐	DVA No.		
Has patient attended this hospital?	Yes ☐	No ☐	Is an interpreter required?	Yes ☐	No ☐
Austin UR			If yes which language?		