

GENETICS REFERRAL FORM



Email: genetics@austin.org.au

Telephone: (03) 9496 3027

Fax: (03) 9496 4385

REFERRAL SOURCE / DR STAMP:	CLIENT DETAILS:
Dr	Name:
Address:	Address:
Phone:	
Fax:	Email:
Provider No:	Home Phone:
Email: Signature:	Mobile:
	Date of Birth:
DATE OF REFERRAL:	Male Female
Duration:	Medicare No:

UNIT REQUIRED: Clinical Genetics	HEAD OF UNIT: Dr Ainsley CAMPBELL
CLINICAL URGENCY: Urgent or Routine	Pregnant

If urgent, please phone and discuss with the duty Genetic Counsellor on 03 9496 3027

REASON FOR REFERRAL:

REFERRAL VALID FOR:

CLIENT INFORMATION:Is the patient Aboriginal?Yes or NoIs the patient a veteran?Yes or NoIs the patient Torres Strait Islander?Yes or NoDVA No:Yes or NoHas the patient attended this hospital?Yes or NoInterpreter required?Yes or NoIf Yes: which language?Yes or NoYes or NoYes or No

Austin UR:

CURRENT MEDICATIONS:	RECENT INVESTIGATION RESULTS:	PAST HISTORY:
Attached: Yes or No	Attached : Yes or No	Attached: Yes or No

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