

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

Previous Genetic Testing results attached

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