Referral Form

GenomiCare

Fill out our referral form and fax it to 1 (866) 961-5091

Referral Type: *

- ☐ Clinic Billing / Donor Billing
- ☐ Patient Pay

URGENT

- ☐ Book within next 3-5 business days

Patient First Name *

Patient Last Name *

Chart Number / Clinic Identifier

Patient Email Address *

Patient Phone Number*

Partner Full Name (optional)

Reason for Referral

(SPECIFIC DETAILS REQUIRED TO ENSURE APPROPRIATE TRIAGE/GENETIC COUNSELLING)

- ☐ Pre PGT-A consult (Genetics and Fertility)
- ☐ Post PGT-A consult – *Please include a copy of the results and recent consult letter*
- ☐ Genetic Counselling / Comprehensive Assessment – family history of genetic condition/birth defects or previous child with genetic condition/birth defects – *Please include a copy of the results and recent consult letter*
- ☐ Set up Expanded Carrier Screening (ECS)
- ☐ Donor Selection Support - Please include donor profile numbers if available in the space provided below.
  Patient is a:
  - ☐ Donor ☐ Intended Parent(s) ☐ Embryo donation
  - ☐ *Select if part of anonymous donor program* * (Chart Number) _____
  - ☐ *Select if part of known donor program* * (Chart Number) _____
- ☐ Other / Comprehensive Assessment - *Please include a copy of the results and a recent consult letter. Indicate reason for referral below:*

Referral Message:

Referral Clinic Name *

Referral Clinic Email Address and/or Fax Number *

Referring Physician Name *

Billing Number *