Fred A. Litwin Family Centre in Genetic Medicine
University Health Network & Mount Sinai Hospital
60 Murray St. Box 34
Tel: 416-586-4800 ext. 4220
Fax: 416-619-5523

Please provide all patient demographics

REFERRAL FORM TO ADULT GENETICS

Referral From: _____ ***Date:*** _____

_____

Signature

Referring physician information-Please print clearly (important for OHIP billing & returning correspondence)

Name/OHIP # _____ Tel #: _____

Specialty _____ Fax #: _____

Mailing Address:

_____

_____

_____

Patient Information:

MRN (UHN/MSH): _____

Name: (*Last, First*): _____

OHIP card # _____ Version Code (*if applicable*) _____

DOB: *dd* _____ *mm* _____ *yyyy* _____ Sex: *(circle)* M F

Mailing Address: _____ Tel #: (h) _____

_____

_____ (w) _____

Reason for Referral (please include all relevant clinical documentation): _____

_____

_____

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