GENETIC COUNSELLING REFERRAL FORM

Please fax completed forms to **403-220-2543** OR email to maya.binet@ucalgary.ca (please cc: gerald.pfeffer@ahs.ca), as per your institutional policies.

Referring Physician	
Name	
Clinic location	
Phone number	Fax number

Patient Demographics	
Full name	Patient aware of this referral and agrees to it ☐ Yes ☐No
Phone number	Preferred language ☐ English ☐ French ☐ Other _____

Reason For Referral (*please include as many relevant details as possible*)

Relevant Family History Information

Supporting Documentation
If genetic testing has been done, please fax the results report with the referral, or the referral will be declined.

Signature	**Date** *(MM-DD-YYYY)*