**GENETICS REFERRAL FORM**

**Please complete the form as fully as possible to ensure that you are offered an appointment appropriately and email it to** **geneticonsultation@gmail.com** **for a rapid response.**

Patient’s Name:

Sex: M/F/Not specified

Date of Birth:

Contact

Email address:

Phone:

**I would like a Genetics Consultation online because:**

(***Delete all that does not apply)***

1. I/ My child has a confirmed genetic diagnosis (confirmed by genetic testing) and I want to know more about the diagnosis.

The name of his/her genetic disorder is …………………..

1. I/ My child has a suspected genetic disorder and I want to confirm it.

The name of the suspected genetic diagnosis is ………………..

1. I want to check if I/ my child has a genetic disorder.

He/She has :

* Developmental delay
* Looks different to the rest of the family
* Birth defects :

Heart defect

Brain Abnormality

Cleft lip +/\_ palate

Kidney abnormality

Genital abnormality

Limb abnormality

Eye abnormality

Spine and bone abnormality

* Growth problems (too big/ too small)
* Neurological problems- muscle weakness, seizures
* Intellectual disability
* Behavioural problems- eg. sleep problems, autistic spectrum disorder, ADHD
1. I have a family history of a genetic disorder and want to know the risk of this affecting me and/or my children.

The name of the genetic disorder in my family is:

1. Other

My reason for a referral is……………………….

**Need for interpreter**:

I am not able to speak fluently in English. My native language is……………….

I would like to have an interpreter if available.