UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute

MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex

ADULT GENETIC NEW PATIENT REFERRAL FORM

Fred A Litwin Family Centre for Genetic Medicine
60 Murray Street, 3rd floor, rm 400, Toronto, Ontario M5T 3L9
Phone: 416-586-4800 ext 4220 **Fax:** 416-619-5523

PATIENT INFORMATION

Last Name:			Place Patient stamp or sticker here if available
First Name:			
Health Card #:	Version Code:		
Date of Birth (dd/mm/yyyy):			
Street Address:			
City:	Province:	Postal Code:	

Phone (Home):	Phone (Cell):	Phone (Work):
Patient Email:	Sex: Gender:	Preferred pronouns:

Fluent in English: YES ☐ If NO Preferred Language : Any accessibility concerns? Interpretation services required? YES ☐

REASON FOR REFERRAL:

☐ **Suspected Genetic disorder**

Please send previous genetic test results, consult notes, tests (eg. echo, abdo U/S, brain MRI), labs, family records

☐ **Confirmed Genetic disorder for counselling or mgt advice**

Please attach genetic test (GT) result

Has patient been informed of diagnosis? Yes ◯ No ◯

☐ **Family member/ partner with genetic condition**

Relationship/name of family member if avail: (attach GT on family member if possible)

Referral details/ info re:suspected or confirmed genetic diagnosis

☐ **Is this referral urgent? If yes, pls explain rationale**

CLINICAL INFORMATION

Please include:

- **All genetic testing results**
- Referral Letter/Consult Note(s)
- Copies of previous investigations/ other lab results
- Records of family members, if relevant to referral and with consent

- Is this a referral for **Marfan syndrome, Retinal Dystrophy, Hemochromatosis, Hemoglobinopathies, Familial Hypercholesterolemia, Congenital Adrenal Hyperplasia?** Please see page 2 of this referral form.
- Is the patient **pregnant** ? If so, is this referral for a **FETAL genetic concern/risk**? If YES: Please send a referral to Mt Sinai Prenatal Genetics
- Is this **a breast/ovarian, melanoma, prostate, endocrine, kidney cancer referral?** If YES: Please send to UHN Familial Cancer Clinic
- Is this a **colon/polyposis/pancreas CA referral?** If YES: Please send to the Mount Sinai Familial GI Cancer Clinic
- Is this a consult for **Neurofibromatosis**? If YES:Refer patient to UHN NF clinic fax: 416-340-4189.
- Is this a consult for **Ehlers-Danlos syndrome**? If YES: Please refer to TGH EDS clinic
- Is this a consult for **Huntington Disease**? IF YES: Please refer to NYGH HD clinic
- Is this a consult **for thrombophilia?** If YES: Please refer to TGH Thrombosis Clinic
- Has the patient been seen **as an adult by another genetics clinic?** Please re-refer to that clinic
- Does the patient **live outside of the GTA** (and NOT followed by any other UHN/Sinai services**?**) Please refer to a genetics clinic closer to their home

REFERRING PHYSICIAN INFORMATION

Referring Physician Name: OHIP billing # Phone Fax

Other physicians to copy:

- **Waitlist**: For most non-urgent referrals is 12-18 months. Referrals for urgent indications are seen sooner.
- **Booking**: We will send a confirmation of receipt of this referral. We notify patients 1-2 months prior to their appointment date. Our team will make 2 attempts to book your patient via phone/email.
- **OTN e-consult:** Our team (includes Drs Nimmo, Faghfoury, Morel and Kim) is available for straightforward questions and can also be reached under the OTN group: "Adult Genetics Specialty Program, University Health Network"

Our centre accepts referrals for patients for many indications, including the evaluation of intellectual disability/autism, multiple malformations, and patients suspected of having a cardiac, neurological, or metabolic genetic disorder.**Please note additional considerations for specific referrals below:**

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RE:Patient Last name

First name

Hemoglobinopathy Counselling

Our clinic is only accepting referrals for patients who are at significant risk of having a child with a hemoglobinopathy. **Their partner must also be referred.**

We will only accept referrals in individuals where:

- ❑ MCV is <80 in both patient and partner **OR**
- ❑ ONE partner has MCV<75 + normal ferritin **OR**
- ❑ Abnormal Hb electrophoresis in both partners
- ❑ CBC, ferritin, hemoglobin electrophoresis is included in referral **for both patient and partner**

Familial Hypercholesterolemia (FH)

Our clinic is accepting referrals for patients **who have Possible, Probable or Definite FH** based on Simon Broome Criteria or Dutch Lipid Network Criteria.

We will only accept referrals that include:

- ❑ Clear documentation of FH clinical diagnosis by criteria above
- ❑ Documentation of cholesterol profile off meds
- ❑ All subspecialty clinic notes (eg. endocrinology or cardiology) and/or relevant results in affected family members

Hereditary hemochromatosis

Our clinic is only accepting referrals for patients with a **high ferritin and elevated transferrin iron saturation** demonstrating iron overload.

We will only accept referrals that include:

- ❑ HFE genetic test results
- ❑ CBC, ferritin, and transferrin iron saturation results

Note: We are not accepting referrals for individuals who have only one mutation on genetic testing (carriers of H63D or C282Y) and normal iron saturation given the high frequency of HFE carriers in the gen population. Please refer to this website for more information about hemochromatosis.

Marfan syndrome

Our clinic accepts referrals for patients who have a clinical diagnosis of Marfan syndrome or who are suspected to have the condition. **Please send any ophthalmology records, cardiology records or any family history records.**

We will only accept referrals that include:

- ❑ Recent (<1yr) echocardiography that includes aortic dimensions

Retinal Dystrophy or Retinitis Pigmentosa

We will only accept referrals that include:

- ❑ Electroretinogram (ERG) and/or
- ❑ Ophthalmology records/clinic notes

Congenital Adrenal Hyperplasia (CAH)

We will only accept referrals that include:

- ❑ 17-OH-P and/or other relevant endocrine lab results
- ❑ Endocrinology clinic notes
- ❑ CYP21A2 genetic test results (requisition found here) **if 21-OH deficiency is suspected**

GENETICS TEAM REPLY TO: Referring Physician **(filled by Litwin team if clarification/ response required)**