

REFERRAL FORM



The Dalglish Family 22q Clinic
Toronto General Hospital
200 Elizabeth Street, Toronto, ON M5G 2C4
8 NU (Norman Urquhart), Room 802
www.22q.ca
Tel: 416-340-5145
Fax: 416-340-5004



Please fax completed form (Please print clearly)

Referring physician: _____

CPSO ID #: _____ Billing #: _____ Specialty: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____

Patient name (Last, First): _____

DOB: (dd/mm/yyyy): _____ UHN MRN (if applicable): _____

OHIP number & version code: _____ OHIP expiry (dd/mm/yyyy): _____

Address: _____

Tel: (Home) _____ (Cell) _____ Email: _____

Patient lives: With family members In a group home Other: _____

Alternate contact person: _____ Relationship to patient: _____

Tel: (Home) _____ (Cell) _____ Email: _____

Family Physician: _____

Is this physician aware of the referral? Yes No The family physician is the referring physician

Address: _____

Phone: _____ Fax: _____

Pharmacy: _____ Address: _____

Phone: _____ Fax: _____

For Office Use Only

Date received:

Date patient contacted:

Date of appointment:

The Dalglish Family 22q Clinic will accept patients with a confirmed or suspected diagnosis of 22q11.2 Deletion Syndrome (22q11.2DS).

Reasons for referral: _____

Which of the following would most benefit your patient, his/her family, and you? (Check all those that apply)

- | | |
|--|--|
| <input type="checkbox"/> Multi-system 22q11.2DS assessment and recommendations | <input type="checkbox"/> Psychosocial / financial support |
| <input type="checkbox"/> Lifetime medical review & clinical summary | <input type="checkbox"/> Dietary and healthy lifestyle education |
| <input type="checkbox"/> Genetic counselling | <input type="checkbox"/> Community based support |
| <input type="checkbox"/> Family support | <input type="checkbox"/> Other: _____ |

Additional information: _____

Signature of referring physician: _____ Date: _____

Please provide us with all the documents you have on the patient.

	Documentation enclosed	Documentation not available	Physician / Hospital
Testing for 22q11.2DS or other genetic conditions	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric history (consult notes)	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac history (echocardiogram, consult notes)	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine issues (consult notes, blood work)	<input type="checkbox"/>	<input type="checkbox"/>	
Immune / auto-immune / hematologic issues	<input type="checkbox"/>	<input type="checkbox"/>	
Assessment of hearing and visual function	<input type="checkbox"/>	<input type="checkbox"/>	
Other relevant health issues: (e.g. renal / abdominal ultrasound) _____	<input type="checkbox"/>	<input type="checkbox"/>	
Intellectual functioning assessment	<input type="checkbox"/>	<input type="checkbox"/>	

Please also attach the patient's current medications list.

Comprehensive clinical information will be very helpful in our multi-disciplinary assessment. 22q11.2DS is a multi-system disorder that displays considerable variation in the spectrum and severity of its expression between individuals. The Dalglish Family 22q Clinic offers expert integrated care using a team approach to provide comprehensive health care services. These include consultation with individuals, families, family physicians, medical specialists and other support persons. Please note that we are an outpatient clinic, not an emergency service.