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): ______________________________ Sex: M F

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: ____

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

- ☐ Multi-system 22q11.2DS assessment and recommendations
- ☐ Lifetime medical review & clinical summary
- ☐ Genetic counselling
- ☐ Family support
- ☐ Psychosocial / financial support
- ☐ Dietary and healthy lifestyle education
- ☐ Community based support
- ☐ Other: ______________________________

Additional information: ____

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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	☐	☐	
Psychiatric history (consult notes)	☐	☐	
Cardiac history (echocardiogram, consult notes)	☐	☐	
Endocrine issues (consult notes, blood work)	☐	☐	
Immune / auto-immune / hematologic issues	☐	☐	
Assessment of hearing and visual function	☐	☐	
Other relevant health issues: (e.g. renal / abdominal ultrasound) ____	☐	☐	
Intellectual functioning assessment	☐	☐	

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.