

# 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](http://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: \_\_\_\_\_

<b>Patient name</b> (Last, First): _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
DOB: (dd/mm/yyyy): _____ UHN MRN (if applicable): _____
OHIP number & version code: _____ OHIP expiry (dd/mm/yyyy): _____
Address: _____
Tel: (Home) _____ (Cell) _____ Email: _____
Primary language(s): _____ Needs an interpreter for medical appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient lives: <input type="checkbox"/> With family members <input type="checkbox"/> In a group home <input type="checkbox"/> Other: _____

<b>Alternate contact person:</b> _____ Relationship to patient: _____
Tel: (Home) _____ (Cell) _____ Email: _____

<b>Family Physician:</b> _____
Is this physician aware of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> The family physician is the referring physician
Address: _____
Phone: _____ Fax: _____

<b>Pharmacy:</b> _____ Address: _____
Phone: _____ Fax: _____

<b>For Office Use Only</b>	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.