Genetics and Metabolism
Health Sciences Centre
Phone: (204) 787-2494
Fax: (204) 787-1419

METABOLIC CLINIC REFERRAL/FAX SHEET

PATIENT INFORMATION:

Date: ____________________

Last Name: ____________________________ First Name: ________________________________

Maiden/Previous Name: ________________________ DOB: ________/_________/_________
(day / month / year)

MHSC#:______________________________ PHIN#:_______________________________

HSC#:_______________________________ Next of Kin: __________________________

Address: ______________________________ City: ______________________________________

Postal Code: ______________________

Phone Numbers: Home: ___________________ Work: ____________________

Cell: _________________

FOR PROMPT PROCESSING OF YOUR REFERRAL, PLEASE ATTACH:

- ☐ Relevant imaging reports (U/S, MRI, CT, X rays)
- ☐ Relevant chemistry/biochemistry/metabolic blood and urine test results
- ☐ Specialist's clinic letters, including developmental assessment report (if completed)
- ☐ A list of medications
- ☐ Growth curves (Height, weight, head circumference)

Is your patient /your patient's partner pregnant? ☐Yes ☐ No

REASON FOR REFERRAL:

____

____

____

____

____

____

REFERRING PHYSICIAN:____
(please print clearly)

ADDRESS:____

TELEPHONE NUMBER: _______________________ FAX NUMBER: ___________________________