GENETIC SERVICES OF WESTERN AUSTRALIA

Genetic Paediatric Service
King Edward Memorial Hospital for Women
Agnes Walsh House
374 Bagot Road, SUBIACO WA 6008
Telephone: **(08) 6458 1625**
Facsimile: (08) 6458 1685
Email: gswa@health.wa.gov.au

GENETIC SERVICES
OF WESTERN AUSTRALIA

PAEDIATRIC REFERRAL FORM

PLEASE FAX COMPLETED REFERRAL FORM TO (08) 6458 1625

PATIENT DETAILS (please affix patient sticker if possible)	
Name:	URN:
Address:	DOB:
Suburb/Postcode:	Telephone:
Interpreter required:	Language:

TYPE OF REFERRAL (priority)	**Reason/s for referral**
☐ **URGENT**	☐ **diagnosis**
	☐ **management implications**
☐ **NON-URGENT**	☐ **testing of siblings/family planning**
	☐ **parental anxiety / support needs**
	☐ **other, please specify** _____

REASON FOR REFERRAL:

PLEASE COMPLETE BOTH SIDES OF THIS FORM

For non-urgent referrals:

- Referrals will only be accepted with relevant health records/correspondence and results
- The family is sent a family history questionnaire to complete and return to us. Once the questionnaire is returned an appointment will be allocated in due course
- If there is a reason your patient cannot complete the questionnaire, please contact us directly to make alternate arrangements

Have other family members previously been seen by a Genetic Service:	☐ **YES**	☐ **NO**
If yes, name of relative & service location: _____		

ATTACHED:
☐ **Chromosome or other molecular genetic testing results (including relevant parental results)**
☐ Relevant specialist consultation letters
☐ Relevant developmental / psychological / educational assessments
☐ Relevant imaging reports (MRI, CT, ultrasound, X-rays)
☐ Relevant specialised testing (audiology, ERG, EMG, EEG, etc)
☐ Facial photographs (frontal and lateral, others as appropriate)

What questions would the family like Genetic Services of WA to answer:

REFERRING DOCTOR:	
Name:	
Ward / Department:	
Contact phone / Fax:	