Health
Nepean Blue Mountains
Local Health District

Facility: Department of Clinical Genetics, Nepean Hospital

ASSESSMENT FOR CLINICAL GENETICS/GENOMICS SERVICE PATIENT REFERRAL

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

Please see *NEPEAN GENETICS REFERRAL CRITERIA DOCUMENT* before considering/sending referral for genetics consultation.

- All referrals MUST contain copies of correspondence, baseline investigations

Nepean Genetics Does NOT accept referrals for:

- Direct to consumer testing; teratogen exposure, medications in pregnancy; paternity/ancestry testing; out of area referrals;
- Ongoing general management of genetic conditions (but if significant concerns, please contact to discuss);
- Cancer genetic testing (Refer to local Familial Cancer Service)

Referral to:

Email referrals to: NBMLHD-Genetics@health.nsw.gov.au	This is an indefinite referral ☐ Yes ☐ No
Correspondence to: PO Box 63 Penrith NSW 2751	Enquiries: (02) 4734 3362

SECTION 1: Specialists available in this department:

Genetics Specialists: ☐ Dr Linda Goodwin ☐ Dr Ingrid Sinnerbrink ☐ Dr Annabelle Enriquez ☐ Dr Madhura Bakshi

ALL OUR SPECIALISTS BULK BILL DIRECTLY TO MEDICARE

SECTION 2: ☐ Genetics Clinic *(any doctor available on the day)*

Referrer details

Name:	☐ Paediatrician ☐ other specialist ☐ GP
Provider #:	Phone:
Email:	Fax:
Signature:	Date: / /
GP name (if not referrer):	Phone:
Address:	Email:

Has the client consented to this referral? ☐ Yes ☐ No

Patient details *(parents MUST be jointly referred with child, consider sibling/s referral if appropriate; refer BOTH partners in a couple for reproductive genetic counselling)*

Name:	**DOB:**	**MRN:**
Name:	**DOB:**	**MRN:**
Name:	**DOB:**	**MRN:**
Name:	**DOB:**	**MRN:**
Address:	**Phone no:** **Phone no:**	
Email:	**Medicare number:**	

Carer name (if appropriate):	Phone:
	Email:

Interpreter required: ☐ Yes ☐ No ☐ Language:

Holes Punched as per AS2828.1: 2019
BINDING MARGIN - NO WRITING

250821

ASSESSMENT FOR CLINICAL GENETICS/GENOMICS SERVICE PATIENT REFERRAL NBMA-074

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GIVEN NAME	☐ MALE ☐ FEMALE
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LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

***** Reason for Referral and Clinical Details MUST be provided *(complete page 2 of this form)***

Reason for Referral: *(eg genetic condition, family history, clinical features etc)*

Urgent Referral *(please call on-call Geneticist on 02 4734 2000)*	☐	☐ Results of this consultation required for urgent medical management decisions ☐ Children under the age of 6 months ☐ Pregnant patient or currently undergoing IVF
Pregnancy Concern:	☐	**Estimated Date of Delivery (EDD):** **Dating ultrasound date/result:** ☐ Genetic condition diagnosed during pregnancy *(attach confirmation of diagnosis + ALL results)* ☐ Patient and/or partner affected by inherited/genetic condition *(attach confirmation of diagnosis + ALL results)* ☐ Family history of an inherited/genetic condition *(attach correspondence and ALL diagnostic/ genetic test results)* ☐ Fetal abnormality suggestive of an underlying genetic disorder *(attach ALL scan/investigation results)*
Pregnancy planning/concern:	☐	☐ Personal and/or family history of a genetic or chromosomal condition *(attach all genetic test results)* ☐ Personal and/or family history of stillbirth/congenital anomalies *(include all information/results)* ☐ Increased risk couple identified for Thalassaemia *(following haematologist consultation – include results)* ☐ Increased risk couple identified on Reproductive Carrier Screening *(include test results)*
Personal history genetic condition	☐	☐ Rare genetic or chromosomal diagnosis *(attach ALL correspondence/copies of investigations + results)* ☐ Congenital anomalies and/or significant developmental delay *(attach baseline investigations/ correspondence)* ☐ Suspected syndrome/genetic diagnosis *(attach baseline investigations/correspondence)*
Family history genetic condition: *(Please prompt patient to obtain family genetic test results to assist risk assessment)*	☐	☐ Inherited/genetic condition in the family *(include all information/results)* ☐ Family history of intellectual disability and/or congenital anomalies *(include all information/results)*
Approval for: Paediatrician ordered Genomic Testing *(under MBS)*	☐	☐ Follow the NSW Health education resource for paediatricians regarding genomic sequencing in childhood for guidance before contacting us – https://www.genetics.edu.au/health-professionals/genomics-1/intellectual-disability-genomic-testing ☐ Attach completed 'Exome/Genome Test Request Form' (SEALS/CHW) ☐ Attach copies of baseline investigations including relevant phenotype information *(see **NEPEAN GENETICS REFERRAL CRITERIA DOCUMENT**)*

Other clinical details *(including family history/relative details)*:

Please send this form to:

Please EMAIL to Nepean Clinical Genetics Service on NBMLHD-Genetics@health.nsw.gov.au
If this is an **Urgent Referral**, please call on-call Clinical Geneticist via the main hospital switch on 02 4734 2000

NO WRITING