



Facility: Department of Clinical Genetics,
Nepean Hospital

**ASSESSMENT FOR CLINICAL
GENETICS/GENOMICS SERVICE
PATIENT REFERRAL**

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
Correspondence to: PO Box 63 Penrith NSW 2751	Enquiries: (02) 4734 3362

SECTION 1: Specialists available in this department:

Genetics Specialists: Dr Ingrid Sinnerbrink Dr Noha Elserafy Dr Annabelle Enriquez Dr Briana Dance

ALL OUR SPECIALISTS BULK BILL DIRECTLY TO MEDICARE

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

Referrer details

Name:	<input type="checkbox"/> Paediatrician <input type="checkbox"/> other specialist <input type="checkbox"/> 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

ASSESSMENT FOR CLINICAL GENETICS/GENOMICS
SERVICE PATIENT REFERRAL

NBMA-074



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
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***** 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)	<input type="checkbox"/>	<input type="checkbox"/> Results of this consultation required for urgent medical management decisions <input type="checkbox"/> Children under the age of 6 months <input type="checkbox"/> Pregnant patient or currently undergoing IVF
Pregnancy Concern:	<input type="checkbox"/>	Estimated Date of Delivery (EDD): _____ Dating ultrasound date/result: _____ <input type="checkbox"/> Genetic condition diagnosed during pregnancy (attach confirmation of diagnosis + ALL results) <input type="checkbox"/> Patient and/or partner affected by inherited/genetic condition (attach confirmation of diagnosis + ALL results) <input type="checkbox"/> Family history of an inherited/genetic condition (attach correspondence and ALL diagnostic/genetic test results) <input type="checkbox"/> Fetal abnormality suggestive of an underlying genetic disorder (attach ALL scan/investigation results)
Pregnancy planning/concern:	<input type="checkbox"/>	<input type="checkbox"/> Personal and/or family history of a genetic or chromosomal condition (attach all genetic test results) <input type="checkbox"/> Personal and/or family history of stillbirth/congenital anomalies (include all information/results) <input type="checkbox"/> Increased risk couple identified for Thalassaemia (following haematologist consultation – include results) <input type="checkbox"/> Increased risk couple identified on Reproductive Carrier Screening (include test results)
Personal history genetic condition	<input type="checkbox"/>	<input type="checkbox"/> Rare genetic or chromosomal diagnosis (attach ALL correspondence/copies of investigations + results) <input type="checkbox"/> Congenital anomalies and/or significant developmental delay (attach baseline investigations/correspondence) <input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/> Inherited/genetic condition in the family (include all information/results) <input type="checkbox"/> Family history of intellectual disability and/or congenital anomalies (include all information/results)
Approval for: Paediatrician ordered Genomic Testing (under MBS)	<input type="checkbox"/>	<input type="checkbox"/> 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 <input type="checkbox"/> Attach completed 'Exome/Genome Test Request Form' (SEALS/CHW) <input type="checkbox"/> 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

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