THE QUEEN'S MEDICAL CENTER

QUEEN'S COMPREHENSIVE GENETICS CENTER
Physicians Office Building 2, 1329 Lusitana St., Suite 506
Phone: 808-686-4780 • Fax: 808-686-2138

Genetics Referral Form

Date: _____

Full name: _____ DOB: _____ ☐ Male ☐ Female

Ethnicity: _____ Primary Language: _____ Marital Status: _____

Address: _____ Primary Contact#_____

Mother/Legal Guardian: _____ DOB: _____ Contact#_____

Father/Legal Guardian: _____ DOB: _____ Contact#_____

Insurance: _____ Subscriber name: _____

Subscriber DOB: _____ Subscriber ID#: _____

Primary Care Physician: _____ Ph#_____ Fax#_____

Referring Physician: _____ Ph#_____ Fax#_____

*****Quest/HMO/Tricare patients will need a PA approval prior to scheduling appt*****

Reason for Referral (check all that apply):

☐ Confirmed congenital hearing loss ☐ Intellectual Disability ☐ Autism ☐ Language Delay

☐ Vascular birthmarks ☐ Failure to Thrive ☐ Short Stature

☐ Abnormal skin pigmentation ☐ Asymmetry/hemihypertrophy ☐ Café au lait macules

☐ Overgrowth/Tall Stature ☐ Skeletal Dysplasia ☐ Ichthyosis/scaly skin

☐ Birth defects: _____ ☐ Dysmorphic features: _____

☐ Neurologic symptoms: _____

☐ Patient has known/suspected chromosomal or genetic disorder: _____

☐ Family history of chromosomal or genetic disorder: _____

Other: _____

Has patient had prior genetic testing or pending genetic test results? Yes or No

If yes, name of test and lab: _____

******Please attach clinical notes that includes problem list, medications, family history, etc. and/or prior genetic test results ******