## **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: <a href="mailto:gswa@health.wa.gov.au">gswa@health.wa.gov.au</a>



## PAEDIATRIC REFERRAL FORM

PLEASE FAX COMPLETED REFERRAL FORM TO (08) 6458 1685

PATIENT DETAILS (please affix patient sticker if p	ossible)		
Name:		URN:	
Address:		DOB:	
Suburb/Postcode:		Telephone:	
Interpreter required:		Language:	
TYPE OF REFERRAL (please indicate priority)	Reason/s for refer	rral	
Ward consult	☐ diagnosis		
☐ Urgent (to be seen within 2 days) ☐ Non-urgent (to be seen within 3-5 days)	☐ management implications		
	<ul><li>□ testing of siblings/family planning</li><li>□ parental anxiety / support needs</li></ul>		
Outpatient appointment			
<ul><li>☐ Urgent (to be seen within 4-6 weeks)</li><li>☐ Non-urgent</li></ul>	□ other, please spe	other, please specify	
REASON FOR REFERRAL:			
REPOORT OF THE ENGLE.			

\*\*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

	bers previously been seen by a Genetic Service:	☐ YES	□ NO
If yes, name of relative a	& service location:		
ATTACHED:			
	er molecular genetic testing results (including relevant	parental results)	
☐ Relevant specialist cor	nsultation letters		
☐ Relevant development	tal / psychological / educational assessments		
☐ Relevant imaging repo	orts (MRI, CT, ultrasound, X-rays)		
☐ Relevant specialised to	esting (audiology, ERG, EMG, EEG, etc)		
☐ Facial photographs (fro	ontal and lateral, others as appropriate)		
What questions would ti	the family like Genetic Services of WA to answer:		
REFERRING DOCTOR:			
Name:			
Ward / Department:			
Contact phone / Fax:			