# W:\Genetics\1.  DEPARTMENT\Logos\GSWA\GSWA bw logo.tifGenetic 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

**PAEDIATRIC REFERRAL FORM**

**PLEASE FAX COMPLETED REFERRAL FORM TO (08) 6458 1685**

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

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| **TYPE OF REFERRAL (please indicate priority)** | **Reason/s for referral** |
| **Ward consult*** Urgent (to be seen within 2 days)
* Non-urgent (to be seen within 3-5 days)

**Outpatient appointment*** Urgent (to be seen within 4-6 weeks)
* Non-urgent
 | □ **diagnosis** □ **management implications**□ **testing of siblings/family planning**□ **parental anxiety / support needs**□ **other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **REASON FOR REFERRAL:** |
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**\*\*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

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

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

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

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