asiagenomics

Transforming Clinical Care through Genomics

Genetic Counseling Referral Form

Date of referral : _____

Name of referring doctor :_____ Clinic / Hospital :_____

Contact details : Telephone_____Mobile _____Email_____

(Please tick above the preferred mode of contact)

Information on Case Referred

Name of Patient :_____

Patient contact details: Telephone_____Mobile _____Email_____

(Please tick based on relevance)

☐ **Pediatric Genetics**

- ☐ Chromosome disorder
- ☐ Family history of inherited disorder
- ☐ Skeletal dysplasia
- ☐ Dysmorphic features
- ☐ Developmental delay
- ☐ Muscular dystrophy
- ☐ Inborn error metabolism
- ☐ Thalassemia/Hemaglobinopathies
- ☐ Others_____

☐ **Reproductive Genetics**

- ☐ Prenatal Screening – NIPT
- ☐ Prenatal diagnosis – CVS/Amnio
- ☐ > than 3 miscarriages
- ☐ Carrier screening
- ☐ Exposure to teratogen in pregnancy
- ☐ Others _____

☐ **Cancer Genetics**

- ☐ Bowel/Colon cancer
- ☐ Breast cancer
- ☐ Ovarian Cancer
- ☐ Other cancer _____

☐ **Others** _____

Reason of referral (Please attach family history, medical report or genetic test results if available)

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All information will be managed with strict confidentiality. Referring doctor will be contacted first before any contact is made to patient. Please email the completed form to counseling@asia-genomics.com or by fax. Thank you.

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