

Requisition form Genetic counselling and/or genetic testing

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Patient

Name: _____ Telephone: _____
DOB: _____ Email: _____

Genetic counselling

Meeting with a genetic counsellor.

This service includes:

- Review and assessment of medical and family history
- Discussion of potential risks for genetic conditions
- Explanation of genetic testing options, including relevance and possible outcomes
- Summary letter provided to patient and referring physician

Reason for genetic counselling: _____

Genetic testing*

Genetic test and authorization to communicate the results
to the patient in follow-up genetic counselling (included with test) for:

- Hereditary cancer (e.g. breast, ovarian, colorectal, prostate)

Comments: _____

*Genetic counselling is recommended before any genetic testing.

Relevant medical or family history:

Physician signature: _____ Date: _____

Name of physician: _____ Permit number: _____