personalized prescribing
next gen pharmacogenetics

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REFERRAL FORM

For Genetic Drug Compatibility (Pharmacogenetic) Testing

Date: ____

Referring Physician Information

Physician´s name: ____

- ◯ Family Doctor
- ◯ Psychiatrists
- ◯ Other (please specify) ____

Address: ____

Postal code: ____ Phone: ____ Fax: ____

Province: ____ e-mail: ____

Type of practice: ____ ____

Patient´s Information

Patient´s name: ____

Address: ____

Postal code: ____ Phone: ____ e-mail: ____

Sex:
- ◯ Female
- ◯ Male
- ◯ Rather not say

Date of birth: ____ Province: ____

Psychiatric Diagnosis

____

Comorbidities

____

Current Medication(s) and Dosage

____

Insurance Provider

Is your patient currently insured by any of the following providers?

- ☐ Manulife
- ☐ RBC Insurance
- ☐ Equitable Life
- ☐ Other ____

Does you patient need to provide a Reimbursement Letter to their current benefits provider?

- ◯ Yes
- ◯ No
- ◯ NA

For Internal Use Only

Requisition # ____

Patient # ____

Case Pharmacist ____

Consent form signed
- ◯ Yes
- ◯ No

Consents to share results with treating physician?
- ◯ Yes
- ◯ No