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CLEAR FORM

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: Alberta e-mail:
Type of practice: Other (please specify)

Patient´s Information

Patient´s name:
Address:
Postal code: Phone: e-mail:
Sex: ◯ Female ◯ Male ◯ Rather not say
Date of birth: Province: Alberta

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
- ☐ WSIB
- ☐ 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: Cindy Hsieh

Consent form signed: ◉ Yes ◯ No

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