

REFERRAL FORM

For Genetic Drug Compatibility (Pharmacogenetic) Testing

Date:

Referring Physician Information

Physician's name:

☐ Family Doctor Address:

☐ Psychiatrists Postal code: Phone: Fax:

☐ Other (please specify) Province: e-mail:

Type of practice:

Patient's Information

Patient's name:

Address:

Postal code: Phone: e-mail:

Sex: ☐ Female Date of birth: Province:

☐ Male

☐ Rather not say

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 your 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