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CLEAR FORM

# REFERRAL FORM

*For Genetic Drug Compatibility (Pharmacogenetic) Testing*

Date:

## Healthcare Professional (HCP) Information

Healthcare Professional'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