REFERRAL TO URGENCY GENETICS CLINIC

Genetic Medicine, 6th Floor, Saint Mary's Hospital, Oxford Rd. Manchester
M13 9WL
Telephone Number: 0161 276 6506

FAX COMPLETED FORM TO 0161 276 6145

Please telephone the Dept to ensure fax has been received and post hard copy.

Patient Name:	**D.O.B**
Telephone Numbers Daytime: Evening:	**Hospital Number:**
Address:	**Gestation:** **L.M.P:**
Referring hospital:	
G.P Address: **Telephone Number:**	**Referrer:** **Contact Number:**
Reason for Referral:	
Patient Aware of Referral to genetics. Yes No	
Referring Consultant:	**Signature of Referrer:** …………………………………………………
DATE	