

Genetics Consultation Services • Yale School of Medicine • Department of Genetics
333 Cedar Street / Room WYW305 / PO Box 208005 / New Haven, CT 06520
Telephone: 203-785-2660 • Fax: 203-785-3404

Date:

New referral. Please fax to initiate referral.

Referred to: (all attempts will be made to schedule patient with requested provider; however, time frame criteria will take precedence unless specified).

Genetics Clinic:

Allen Bale, MD _____
Cheryl Garganta, MD, PhD _____
Maurice J. Mahoney, MD, JD _____
James McGrath, MD, PhD _____
Margretta Seashore, MD _____

Cardiac/Genetics Clinic _____
Bridgeport Clinic _____
Danbury Clinic _____
Greenwich Clinic _____

Patient Data:

Name:
DOB:
Address:

Parents/Guardian Name (if minor):

Phone Number: Day:

Evening:

Insurance Company Name (*please initiate referral if needed*):

Phone Number:

ID Number:

Group Number:

Diagnosis:

Reason for Referral / Brief History:

Medications:

Has parent/guardian/patient been notified of your referral to the Genetics Clinic? _____ *Yes*
_____ *No*

****PLEASE INFORM YOUR PATIENT THAT THEY WILL BE CONTACTED WHEN AN APPOINTMENT BECOMES AVAILABLE.****

Referral Time Frame Requested: ≤1Month: _____ 1-3 Months: _____ Next Available: _____

Referring Provider Information:

Name:

Address:

Phone Number:

Fax Number:

Would you like to discuss this with someone from our office? _____ Yes _____ No

For Office Use Only

Date Received:

Appointment Date: _____ Time: _____ Made by: _____ Staff Initials: _____
Parent/Guardian/Patient Notified: Conversation: _____ Date: _____ Time: _____ Staff initials: _____
Appointment Date/Time Faxed Back to PCP/Ref MD: Date: _____ Time: _____ Staff initials: _____

PLEASE ATTACH ALL PERTINENT RECORDS INCLUDING LABORATORY RESULTS, X-RAY REPORTS, EVALUATIONS, ETC. WHEN RETURNING THIS FORM TO GENETICS.