THE UNIVERSITY OF BRITISH COLUMBIA

Department of Medical Genetics

Study Referral Form: ***Silent Genomes: Precision Diagnosis for Indigenous Families with Genetic Conditions***

Date of Referral: _____

Patient Information:

Last Name: _____ First Name: _____

DOB: _____ Sex: _____

Guardian Last Name: _____ Guardian First Name: _____

Address: _____

_____

Phone: _____ Email: _____

Alternate Phone/Email: _____

Reason for referral: _____

_____

_____

_____

Has the patient signed a *Precision Diagnosis study 'Authorization to Release Healthcare Information' form* (to facilitate records review and eligibility confirmation)? ☐ Yes (*please attach*) ☐ No

By signing the form below, I, the referring physician, confirm the following:

1. The patient, named above, and/or their legal guardian, has been notified about the Precision Diagnosis Study and is interested in learning about the study in more detail. They have either (*please check one*):
   - ☐ Agreed to release their contact information and are expecting to be contacted by the study team
   - ☐ Expressed interest in initiating contact with the study team and have been provided our contact information
2. Should the patient agree to participate in the Silent Genomes Study, I agree to return all relevant results to him/her/the family.

Referring Physician:

Last Name: _____ First Name: _____

Phone: _____ Signature of Referring Physician: _____

Study Contacts:

Victoria site: **Sarah McIntosh** e-mail: sarahmc@uvic.ca tel.: 250-853-3262 fax: 250-472-4283

Vancouver site: **Karen Jacob** e-mail: karen.jacob@bcchr.ca tel.: 604-875-2000 x5271 fax: 604-875-2376