



Genetic counselling referral form

To be eligible for this service:

- Both partners must be carriers for the same autosomal recessive disorder, or the female partner is a carrier for an X-linked disorder.
- At least one partner must have had carrier testing through Sonic Genetics. (If the other partner has been tested at another laboratory, a copy of that report must be provided).
- The referral for genetic counselling must be received within two months of the date that the latest carrier screening report was issued by Sonic Genetics.

FOR THE DOCTOR: Please complete the following and fax to 1800 951 829

Patient details

First name _____

Surname _____

Date of birth ____ / ____ / ____ Sex _____

Address _____

Phone _____

Laboratory ID _____

Partner details

First name _____

Surname _____

Date of birth ____ / ____ / ____ Sex _____

Address _____

Phone _____

Laboratory ID (if tested) _____

OR ☐ Copy of carrier screen result attached

Clinical information

This couple has been identified at high risk for having children with:

- ☐ Cystic fibrosis
- ☐ Spinal muscular atrophy
- ☐ Fragile X syndrome
- ☐ Other (please specify) _____

This couple is:

- ☐ Pregnant
- ☐ Not pregnant

Gestational age (weeks) _____

Requesting doctor

The couple is aware that genetic counselling has been requested on their behalf and that a genetic counsellor will contact them directly to arrange counselling.

Name _____

Address _____

Phone _____

Provider No _____

 DOCTOR SIGNATURE

I understand that the counsellor will advise me when the session has been completed or if it is declined.