**Inpatient Genetics Consult Referral Form**

Please fax this form with complete documentation to: 406-444-1064

Once we receive this information, we will be in contact the unit to schedule a consultation.

*Patient Name:* _____ *DOB* _____

**Please complete necessary information:**

Question for genetic consult

_____

_____

Clinical Information

Shodair Unit: _____ Unit phone number/contact person: _____

Referring Psychiatrist: _____

Provider completing form: _____

This evaluation is:

- o Urgent
- o Non-urgent.

Relevant Family History

Birth and early development:

- Gestational Age: _____
- Teratogenic exposures? _____
  - If so, what and how much? _____
- Delivery complications? _____
- Delays in milestones?_____ Walked at age:_____ First words (age):_____

Problem list:

- Reason for Shodair admission: _____
- Developmental delay? _____
- Grade in School _____ IEP? _____
- Developmental assessments/neuropsychological evaluations? _____ (if yes, please include with referral)

Past Medical History- Please list

_____

_____

_____