MEDICAL GENETICS PROGRAM
Medical Genetics Clinic
Telephone 250-727-4461
Fax 250-727-4295
Email medicalgenetics@viha.ca

Victoria General Hospital
1 Hospital Way
Victoria, BC V8Z 6R5

Reason for referral: _____

Referred by: _____

The information on this form will help us gather more information about your child's referral. It is important that we receive this form before your child's appointment in order to accurately assess your child's referral in the context of your family information. **Please complete as much information as you can and return this form in the envelope provided, by fax or by email as soon as possible.** The more details you provide, the more accurate our assessment will be.

Tips for completing this form:

- Please print clearly.
- If you need more space for any section, please attach an extra page.
- Provide the name(s) that your relatives commonly use if different from their given name(s).
- Approximate information is okay. If you do not have exact information, please provide your "best guess".
- This information will be kept on file as part of your child's Medical Genetics medical record. We will not share this information with others unless we have consent either from you or, when your child is an adult, them.

If you have any questions or concerns about this form, please contact the Medical Genetics reception at 250-727-4461, located at the Victoria General Hospital.

QUESTIONNAIRE - PEDIATRIC

Patient's Name: _____ (Last Name) _____ (First Name) _____ (Date of Birth) VI # _____ (Our Reference No.)

Address: _____ (Street) _____ (City) _____ (Postal Code)

Telephone: _____ (Home) _____ (Work) _____ (Cell) _____ (Other)

_____ (Name of person completing form) _____ (Relationship to Patient) _____ (Date)

Who does the patient live with?

Birth parents ☐Mother ☐Father *Adoptive parents* ☐Mother ☐ Father *Other* ☐_____
Step parents ☐Mother ☐Father *Foster parents* ☐Mother ☐Father

Please use this space to list any question or concerns about your child that you would like addressed at the appointment.

_____

_____

_____

_____

_____

_____

Has another person in your family been seen in a Medical Genetics Clinic or had genetic testing?

☐No ☐Yes ☐Unsure If yes, Name of family member: _____
For what condition: _____
Where and when: _____

FOR OFFICE USE ONLY

Referral Date: _____

Date Received: _____

PREGNANCY DETAILS

Were there any complications during the pregnancy? e.g. illness, bleeding, injury, reduced fetal movement, or ultrasound findings
☐No ☐ Yes, please list _____

Were any of the following medications or substances used? e.g. prescription medications, cigarettes, alcoholic beverages, drug exposure, herbal remedies
☐No ☐ Yes, please list _____

Was the delivery on time? ☐Yes ☐No If no, how many weeks early? _____ or how many weeks late? _____

Method of Delivery: ☐ Vaginal delivery ☐Forceps or vacuum used in delivery ☐ Caesarean Section

Birth weight: _____

Were there any problems immediately after birth? e.g. baby turned blue; jaundice; feeding problems
☐No ☐Yes, please list _____

YOUR CHILD'S HEALTH

Are there any concerns about your child's:

SKIN e.g. light or dark birth marks; unusual hair or nails; bumps; rashes; absent sweating
☐No ☐ Yes _____

EYES e.g. near-sighted; far-sighted; colour blindness; night blindness; cataracts; lazy eye
☐No ☐ Yes _____

EARS e.g. hearing loss; more than 2 infections per year; ringing
☐No ☐Yes _____

NOSE e.g. poor sense of smell; frequent colds; nosebleeds
☐No ☐ Yes _____

MOUTH / TEETH e.g. cleft lip or palate; early or late eruption of teeth; unusually formed teeth; problems with teeth, gums, or tongue
☐No ☐ Yes _____

THROAT / NECK e.g. difficulty swallowing, hoarse voice
☐No ☐ Yes _____

HEAD / BRAIN e.g. headaches; dizziness; seizures; large or small-sized head
☐No ☐Yes _____

HEART e.g. structural defect; murmur; irregular heartbeat; chest pain; high blood pressure
☐No ☐Yes _____

BLOOD e.g. easy bruising; easy bleeding; blood clots; stroke; low blood count
☐No ☐Yes _____

LUNGS e.g. asthma; chronic wheezing or cough; pneumonia
☐No ☐Yes _____

STOMACH / INTESTINES e.g. avoiding specific foods; frequent vomiting; reflux disease; constipation; diarrhea; bad diaper rash
☐No ☐Yes _____

URINARY TRACT / GENITALIA e.g. kidney problems; bladder infections; bed wetting; blood in urine; abnormal genitalia
☐No ☐Yes _____

MUSCLES e.g. weakness; coordination difficulties; paralysis; tight muscles
☐No ☐ Yes _____

ENDOCRINE SYSTEM e.g. diabetes; thyroid problems; concerns with weight or growth
☐No ☐Yes _____

BONES / EXTREMITIES e.g. fractures; abnormal number or shape of fingers or toes; disproportion; tight joints
☐No ☐ Yes _____

Has your child had any surgeries, major illnesses or prolonged hospitalizations?
☐No ☐Yes, please list _____

Is your child currently taking any medication?
☐No ☐Yes, please list _____

Please list any investigations your child has had that might be useful for our assessment: e.g. MRIs, muscle biopsies, blood tests

Type of investigation	Date	Location	Type of investigation	Date	Location

Please list any other specialists/health care providers who has seen or been following your child:

Name	Speciality	Location	Name	Speciality	Location

YOUR CHILD'S DEVELOPMENT

At about what age did your child do the following (if applicable):

Walk without support _____
Use single, meaningful words _____
Put two or three words together _____
Scribble _____
Feed self using spoon _____
Toilet trained during daytime _____

Does your child have any behavioural difficulties?
☐No ☐Yes, please describe _____

Is your child receiving any developmental services or has your child had such aid in the past? e.g. IDP, physio, speech therapy
☐No ☐Yes, please describe _____

Are there any other special considerations about your child that we should be aware of?
☐No ☐Yes, please describe _____

SIBLING DETAILS

Please list all of the patient's brothers/sisters, and any pregnancy losses experienced by the patient's biological parents.
If there are any half-brothers or half-sisters, please indicate if they have same mother or father to the patient.

	Name *or* pregnancy outcome (miscarriage, stillbirth, etc.)	Age *or* Date of Birth	Sex (M/F)	Medical or learning problems (if yes, please provide details)
1				☐No ☐Yes
2				☐No ☐Yes
3				☐No ☐Yes
4				☐No ☐Yes
5				☐No ☐Yes

Were any of these children adopted?
☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family: _____

BIOLOGICAL PARENT DETAILS

Are the patient's biological parents related by blood? e.g. first cousins
☐No ☐Yes If yes, please explain relationship _____

BIOLOGICAL MOTHER DETAILS

Please provide the following details about the patient's biological mother and her family:

_____ _____ _____ _____
Last Name First Name Date of Birth PHN/Care Card # (optional)

Does she have any medical or learning problems? ☐Yes ☐No If yes, please provide details: _____

What is her race/ethnic ancestry? *(Please list all that apply)* _____
e.g. Chinese, English, First Nations, Greek, Punjabi, Ashkenazi

BIOLOGICAL MOTHER'S SIBLINGS: Please list the patient's mother's brothers/sisters (the patient's aunts and uncles).

	Name	Sex (M/F)	Still living?	Health problems and/or cause of death	Their children
1			☐Yes: Current Age _____ ☐No: Age at Death _____		# of Male: # of Female:
2			☐Yes: Current Age _____ ☐No: Age at Death _____		# of Male: # of Female:
3			☐Yes: Current Age _____ ☐No: Age at Death _____		# of Male: # of Female:
4			☐Yes: Current Age _____ ☐No: Age at Death _____		# of Male: # of Female:

Were any of these children adopted?
☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family: _____

Do all of these aunts/uncles share the same 2 parents?
☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

_____

BIOLOGICAL MOTHER'S MOTHER (maternal grandmother) Name: _____
Still living? ☐Yes ☐No If no, age and cause of death (if known): _____

BIOLOGICAL MOTHER'S FATHER (maternal grandfather) Name: _____
Still living? ☐Yes ☐No If no, age and cause of death (if known): _____

BIOLOGICAL FATHER DETAILS

Please provide the following details about the patient's father and his family:

Last Name _____ First Name _____ Date of Birth _____ PHN/Care Card # (optional) _____

Does he have any medical or learning problems? ☐Yes ☐No If yes, please provide details: _____

What is his race/ethnic ancestry? *(Please list all that apply)* _____
e.g. Chinese, English, First Nations, Greek, Punjabi, Ashkenazi

BIOLOGICAL FATHER'S SIBLINGS: Please list the patient's father's brothers/sisters (the patient's aunts and uncles).

	Name	Sex (M/F)	Still living?	Health problems and/or cause of death	Their children
1			☐Yes: Current Age _____		# of Male:
			☐No: Age at Death _____		# of Female:
2			☐Yes: Current Age _____		# of Male:
			☐No: Age at Death _____		# of Female:
3			☐Yes: Current Age _____		# of Male:
			☐No: Age at Death _____		# of Female:
4			☐Yes: Current Age _____		# of Male:
			☐No: Age at Death _____		# of Female:

Were any of these children adopted?
☐ No ☐Yes If yes, please list their names and tell us if they were adopted into or out of the family: _____

Do all of these aunts/uncles share the same 2 parents?
☐Yes ☐ No If no, please list the names of those with a different mother or father. Please provide the name of the mother/father.

BIOLOGICAL FATHER'S MOTHER (paternal grandmother) Name: _____
Still living? ☐Yes ☐No If no, age and cause of death (if known): _____

BIOLOGICAL FATHER'S FATHER (paternal grandfather) Name: _____
Still living? ☐Yes ☐No If no, age and cause of death (if known): _____

FAMILY DETAILS

Does anyone in your biological family currently have or have a history of any of the following conditions? Please consider your parents, siblings, nieces, nephews, aunts, uncles, first cousins, and grandparents.

Yes	No	Unsure	Condition	Name and relationship to patient	Details:
☐	☐	☐	Medical problems similar to the patient		
☐	☐	☐	Birth defects		
☐	☐	☐	Intellectual disability/special needs/learning disability		
☐	☐	☐	Chromosome condition (eg. Down syndrome)		
☐	☐	☐	Two or more miscarriages		
☐	☐	☐	Stillbirth or early childhood death		
☐	☐	☐	Cancer under the age of 50		
☐	☐	☐	Any health condition being passed down in the family		

Any questions about this form? Please contact us at 250-727-4461.