NHH
Clinical Telemedicine Consult Request

NHH Clinical Telemedicine Coordinator (TMC)
T: 905-372-6811 x 3050 Email: telemedicine@nhh.ca

FAX to 1-905-373-6972

Patient Name: _____ Health Card: _____

Date of Birth: _____ Phone (Home): _____ (Mobile): _____
Day Month Year

☐**Infectious disease** ☐**Fracture Clinic** ☐**Telederm** ☐**Other:** _____

☐**Clinical Genetics** Reasons for referral include, but are not limited to, intellectual disability/autism, multiple congenital anomalies, and suspected genetic types of neurological (e.g., movement disorders, epilepsy), cardiovascular (e.g., HCM, aortic dissection), endocrine (e.g., MODY, CAH), and ocular (e.g., RP) conditions.

*** Please see second page for additional information to include in the referral.**

☐**Neurology** Referrals that are not appropriate for urgent virtual neurology clinic include concussions, vertigo, chronic conditions i.e., headaches including migraine, established epilepsy and MS already diagnosed/treated. Patients who are already being followed by a neurologist should be seen by their neurologist. **Neurology referrals are for one-time, urgent consult with opinion only and patients will not be seen for ongoing management.** Referrals for paresthesia, neuropathies, etc. should be referred for EMG testing and in person consultation where available.

☐**Rheumatology** Appropriate referrals include inflammatory arthritis, connective tissue disease, vasculitis, spondyloarthropathy, autoinflammatory diseases, or other systemic inflammatory diseases. Referrals that will not be accepted include chronic pain, osteoarthritis, mechanical back pain without imaging evidence of sacroiliitis, or elevated ANA/RF without any clinical signs of inflammation.

Pending/completed tests: ☐**MRI** ☐**CT** ☐**EEG**

Reason for request: _____

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Physician: **Phone:** **Fax:**

Referring Healthcare Provider: **Billing:** **Phone:**

NORTHUMBERLAND HILLS HOSPITAL

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Please note additional considerations for specific genetic referrals below:

CLINICAL INFORMATION	
Please include, as relevant: • All genetic testing results • Referral letter / Consult note(s) • Copies of previous investigations / other lab results • Records of family members, if relevant to referral, and with consent	Referrals that should be directed to different clinics: ➢ Is the patient pregnant? If YES: Please consider sending a referral to a **Prenatal Genetics Clinic**, such as at Lakeridge Health or Peterborough Regional Health Centre ➢ Is this a cancer referral? If YES: Please send to a **Hereditary Cancer Clinic**, such as at Lakeridge Health or Peterborough Regional Health Centre ➢ Is this a consult for **Ehlers-Danlos syndrome**? If YES: Please refer to TGH EDS clinic ➢ Is this a consult for **Huntington Disease**? IF YES: Please refer to NYGH HD clinic ➢ Has the patient been seen at another genetics clinic? Please re-refer to that clinic ➢ Please consider referring to a genetics clinic closer to the patient's home, if the patient does not live near NHH.

Marfan Syndrome		**Hypertrophic Cardiomyopathy**
Please send: • Echo report with aortic dimensions • Ophthalmology and cardiology records • Relevant family history records.		Please send: • Echo report and cardiology records • Relevant family history records.
Monogenic Diabetes / Inherited Endocrine Disorders		**Retinal Dystrophy Retinitis Pigmentosa**
Please send: • Endocrine labs, e.g., HbA1C, anti-GAD • Endocrinology clinic notes		Please send: • Electroretinogram (ERG) and/or • Ophthalmology records/clinic notes
Neurofibromatosis		**Neuropsychiatric conditions**
Please send any dermatology records, ophthalmology records, imaging studies, and any family history records.		Please send any previous neuropsychiatric assessments, neuroimaging records, EMG/NCS, and other imaging (echocardiogram, ultrasounds), as relevant