CONSULTATION FORM FOR GENETIC COUNSELLING

From: Dr. ....

.... Unit

QEH/QMH/PMH/PWH/TMH/ ______

Ref: Hosp./OPD No.: ....

Date: ....

To: Clinical Genetic Service
Cheung Sha Wan Jockey Club Clinic,
2 Kwong Lee Road, Sham Shui Po,
Kowloon

Tel.: 2725 3773 Fax: 2729 1440

Name: (English) .... (Chinese) ....

Sex: Male/Female. Date of Birth: .... Age: .... yrs .... mths

Address: ....

.... Tel. No.: ....

Presently he/she is ☐ an out-patient of .... Clinic

☐ an in-patient in QEH/QMH/PMH/PWH/TMH/ __________

Ward .... Bed No. ....

Presumptive diagnosis: ....

Present History: ....

....

....

....

Positive Physical signs: ....

....

....

Development assessment done on .... at ....

Result: ....

Important investigation results: ....

....

Autopsy/Biopsy reports: ....

....

Family tree (to be drawn at the back):

Family history:

	Name	*Age*	*Nativity*	*Occupation*
Father				
Mother				

Consanguinity: Yes .... /No

Relevant family history: ....

....

Birth history:

Parity: .... Gestation: .... wks. Birth Wt. ....

Neonatal Complications: ....

Pregnancy history:

No. of pregnancies .... incl. .... abortions & .... NND

Complications during pregnancy ....

X-ray exposure: Yes .... /No Drugs: ....

Alcohol (Yes/No)

Smoking (Yes/No)

Labour complications: ....

Remarks: ....

....

Signature..

Name in BLOCK LETTERS ....

DH 2265