

CONSULTATION FORM FOR GENETIC COUNSELLING

From: Dr.
Unit
 QEH/QMH/PMH/PWH/TMH/.....
 Ref: Hosp./OPD No.:
 Date:
 Contact: (Fax) (Tel)

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) HKID:
 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:

	<i>Name</i>	<i>Age</i>	<i>Nativity</i>	<i>Occupation</i>
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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