Department of Clinical Genetics
Children's Health Ireland Crumlin,
Cooley Road, Crumlin, Dublin
D12 N512
Email: clinical.genetics@childrenshealthireland.ie
Telephone number: 01 409 6739

Cascade Referral Form

- **Please send this completed form by post or email, see details above.**
- **All sections of this form must be completed, or we may not be able to accept your referral.**
- **You will receive a letter from our department confirming acceptance to our waiting list.**
- **This form should only be completed by an individual whose biological (blood relative) has already attended our genetic service and has a genetically confirmed diagnosis.**
- **We may not accept your referral for other reasons (too distantly related, not affecting your side of family etc). We will advise you by letter if this is the case.**
- **A separate form must be completed for each family member**
- **Any queries, please contact us at the number above.**

Family number: Ped_____

YOUR (PATIENT) DETAILS:

Name: _____

Date of birth: _____ Sex at birth: _____

Contact number: _____

Email: _____

Address (Let us know if you change your address):

_____

_____ Eircode: _____

GP Name: _____

GP Practice: _____

Practice address: _____

_____

_____

DETAILS OF YOUR RELATIVE KNOWN TO OUR DEPARTMENT:

Family member's name (and date of birth, if known): _____

Relationship to you, indicating which side of family (e.g. sibling, aunt = my mother's sister): _____

_____

Name of genetic condition (diagnosis) and/or gene (if known): _____

Genetic staff member seen by relative (if known): _____

FORM COMPLETED BY (print name)**:** _____

Signature: _____ Date: _____