Learning & Development Clinic
Children, Youth and Families
Addiction & Mental Health
East Edmonton Health Centre
7910 -112 Avenue
Edmonton, AB T5B 0C2

Referral Criteria for Precision Medicine in Autism (PRISMA) Consult Services
Genomic Psychiatry

Genomic Psychiatry Consult Criteria:

(Must meet all criteria for acceptance into this clinic)

1. Clinical diagnosis of autism spectrum disorder or other neurodevelopmental disorder *AND*
2. Genetic testing, specifically chromosome microarray, fragile X, whole exome, whole genome and/or karyotype *AND*
3. Identified abnormal result considered "pathogenic" on such a genetic test

We work in partnership with the referring clinical team to enhance (but not replace) any ongoing psychiatric or primary care. The referring physician must be involved to assist the family with monitoring of ongoing medical concerns, and implementation and continuation of recommendations. By submitting this referral, you are agreeing to participate in shared care for this client by continuing ongoing primary/psychiatric care, including prescribing/refilling any recommended medications after a concerted agreement with you and the family, and agreeing to resume full care once the consult is complete. Patients under the age of 18 must have an identified guardian or parents involved. Please note that we do not provide long term management of patients within these consult services.

The **Genomic Psychiatry Consult Service** offers neuropsychiatric management recommendations based on genetics results and includes a detailed discussion, personalized information, and connection to support groups.

Required Referral Documents and Information

- ☐ Completed physician referral form
- ☐ Confirmed clinical diagnosis of ASD and/or neurodevelopmental disorder
- ☐ Previous genetic testing reports

FAX COMPLETED REFERRAL FORM & REQUIRED DOCUMENTATION TO:

CYF Central Intake
Fax: 780-408-8776
Phone: 825-402-6799
Children Youth & Families Addiction & Mental Health
Nexus Business Park
11642 142 Street NW Edmonton Alberta T5M 1V4

Alberta Health Services

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Name:	Date of Birth:
Address of Primary Residence:	
Gender:	PHN:
Parent/Legal Guardian Name:	Relationship to patient:
Email Address:	Phone Number:
Parent/Legal Guardian Name:	Relationship to patient:
Email Address:	Phone Number:
Interpreter Services needed? Yes / No Language:	
Current Behavioral Health Physician:	
Psychiatric diagnoses:	
	Age at Dx:
	Age at Dx:
	Age at Dx:
Other medical diagnoses:	
	Age at Dx:
	Age at Dx:
	Age at Dx:
What type of genetics test did your patient/your patient's child have? (*Check at least one)*	
	☐ Chromosomal Microarray
	☐ Karyotype
	☐ Fragile X
	☐ Whole Exome/Genome Sequencing
	☐ Other (please specify)
What were the test results? *(Include test reports)*	

All items must be completed to accept the referral. Thank you! ***v1.0 2023***