Hereditary Gastrointestinal Cancer Genetic Diagnosis Laboratory
遺傳性腸胃癌基因診斷化驗室

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Hereditary Gastrointestinal Cancer Genetic Diagnosis Service

Patient Referral Form

Patient information (or attached patient label below):

Name:

Sex/Age:

ID. No.:

Patient contact telephone number (daytime):

Brief clinical history:

Signature:_____

Referring Doctor's Name: _____

Hospital and Unit: _____

Contact phone number: _____

For patient referral, please fill in the patient contact telephone number and fax the form to us, or ask the patient to call us directly.

Contact information:
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給病人的聯絡資料:
請致電我們的聯絡主任
郭緻瑩小姐
遺傳性腸胃癌基因診斷化驗室
香港薄扶林道
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