InformedDNA®
Genetics, Decoded.

Neurogenetics Counseling Referral

FORM FILLING DATE:_____ _____ _____

Patient Information

1

Name:_____ Date of Birth:___ ___ _____

PREFERRED Phone:_____ OTHER Phone:_____ E-mail:_____

Billing

2

☐ Bill to Patient Insurance
* In-network only.

☐ Other (Please Explain)_____

Reason for Referral

3

Personal and/or Family History (known diagnosis):

PATIENT	FAMILY MEMBER	
☐	☐	Duchenne or Becker muscular dystrophy
☐	☐	Myotonic dystrophy (type 1 or 2)
☐	☐	Other muscular dystrophy (i.e. Limb-girdle, Emery Dreifuss)
☐	☐	Charcot-Marie-Tooth
☐	☐	Alzheimer's disease (suspected or known family history, and/or onset <60 years)
☐	☐	Parkinson disease (suspected or known family history, and/or onset <50 years)
☐	☐	Frontotemporal dementia (suspected or known family history)
☐	☐	Amyotrophic lateral sclerosis (suspected or known family history)
☐	☐	Hereditary ataxia
☐	☐	Other neuromuscular, neurodegenerative, or neurometabolic disease
☐	☐	Known gene mutation/neurogenetic condition. Specify:_____
☐	☐	Other:_____

Personal and/or Family History (symptoms):

PATIENT	FAMILY MEMBER	
☐	☐	Young-onset dementia (<60 years)
☐	☐	Ataxia, non-acquired
☐	☐	Cerebellar atrophy
☐	☐	Non-acquired neuropathy
☐	☐	Other:_____

Genetic Test Status

- ☐ Test not yet ordered
- ☐ Test ordered
- ☐ Results received, please provide results interpretation
- ☐ Unknown
- ☐ Other:_____

Patient Documentation - Fax with Referral

4

a. Clinical. Please include the following (if performed)

- ☐ Clinic note outlining history of disease/suspected diagnosis
- ☐ Lab/imaging results (i.e. creatine kinase, brain MRI, EMG, and/or muscle biopsy).**
- ☐ Patient genetic test results
- ☐ Copy of mutation in family (if requesting carrier testing)

b. Patient face sheet (Demographics).

c. Insurance documentation. A copy of front and back of the patient's insurance card.

** We will not provide interpretation.

Provider Information

5

_____ Medical Center/Practice

_____ Practice Contact

_____ Phone

_____ Fax

_____ E-mail

_____ Address

_____ City

_____ State

_____ Zip

_____ **Referring Provider**

_____ Fax *(required)*

_____ NPI

_____ Referring Provider's Signature

Fax completed form to:

6 **(760)203-1194**

www.InformedDNA.com

For questions, please call
800-975-4819