InformedDNA®
Genetics, Decoded.

Ocular Genetic 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

Patient or close family member with suspected or known diagnosis of:

PATIENT	FAMILY MEMBER	
☐	☐	Retinitis pigmentosa (RP) or retinal degeneration
☐	☐	Stargardt's or Best's macular dystrophy
☐	☐	Macular degeneration at age 50 or younger
☐	☐	Leber Congenital Amaurosis (LCA)
☐	☐	Usher syndrome (RP plus deafness)
☐	☐	Retinoschisis
☐	☐	Optic Atrophy
☐	☐	Choroideremia
☐	☐	Retinoblastoma
☐	☐	Retinal angioma/hemangioma
☐	☐	Glaucoma at age 40 or younger (not related to eye injury or diabetes)
☐	☐	Coloboma or other developmental eye disease
☐	☐	Known gene mutation/genetic eye condition
☐	☐	Uveal Melanoma

Other_____

Patient or close family member with one of the following symptoms:

PATIENT	FAMILY MEMBER	
☐	☐	Significant peripheral vision loss
☐	☐	Reduced, uncorrectable central vision at age 50 or younger
☐	☐	Blindness at age 60 or younger
☐	☐	Congenital vision loss
☐	☐	High myopia (>-3d) in childhood, retinal detachment, and/or early cataracts

Other_____

Genetic Test Status

☐ Test not yet ordered ☐ Test ordered

☐ Results received, provide results interpretation ☐ Unknown

Other_____

List Test and Lab_____

Patient Documentation - Fax with Referral

4

a. Clinical. Please include the following (if performed) ☐ Pathology reports ☐ Patient genetic test results

☐ Family member genetic test results ☐ Test request form **IF SAMPLE COLLECTED**

b. Patient face sheet (Demographics).

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

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

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