InformedDNA® Adult-Other Specialty Genetic Counseling Referral

Genetics, Decoded.

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

a. Disease Category

- ☐ Adult onset
- ☐ Cancer
- ☐ Reproductive/Prenatal
- ☐ Cardiac
- ☐ Neurogenetics
- ☐ Ocular
- ☐ Other:_____

b. Indication

- ☐ Genetic disease suspected
- ☐ Diagnosis of a genetic disease
- ☐ Family history of disease
- ☐ Gene mutation in family
- ☐ Other:_____

c. Genetic Test Status

- ☐ Test not yet ordered
- ☐ Test ordered
- ☐ Results received
- ☐ Unknown
- ☐ Other:_____

Patient Documentation - Fax with Referral

4

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

- ☐ Clinic note outlining history of disease/suspected diagnosis
- ☐ Test request form (if sample already collected and testing ordered).*
- ☐ Genetic test results
- ☐ Copy of genetic testing results in family (if performed)

b. Patient face sheet (Demographics).

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

d. Lab preference (if sample not already collected)**:_____

* We will not provide interpretation.

** InformedDNA considers test quality, cost and physician preference when selecting a laboratory.

Physician 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