InformedDNA®
Genetics, Decoded.

Reproductive Genetic Counseling Referral

FORM FILLING DATE:____ ____ _____

Patient Information

1

Name:_____ Date of Birth:___ ___ _____

PREFERRED Phone:_____ OTHER Phone:_____

☐ Please expedite genetic counseling for immediate management decisions (2-4 business days)

Billing

2

☐ Bill to Patient Insurance
* In-network only.

☐ Other (Please Explain)_____

Reason for Referral

1. Personal or Family History

3

PATIENT/ PARTNER	FAMILY MEMBER	
☐		Maternal age ≥ 35
☐		Paternal age >/= to 40
☐	☐	≥ 2 miscarriages
☐	☐	Pregnancy loss beyond 20 weeks gestation (stillbirth)
☐	☐	Birth defect. *Specify:*_____
☐	☐	Intellectual disability (e.g., developmental delay, autism)
☐	☐	Chromosome abnormality. *Specify:*_____
☐	☐	Diagnosis of a known genetic disorder. *Specify:*_____
☐	☐	Carrier of a known genetic disorder. *Specify:*_____
☐		Azoospermia/oligospermia
☐		Congenital absence of the vas deferens
☐	☐	Premature ovarian failure

Patient and partner are blood relatives (consanguinity)

☐ Yes ☐ No ☐ Unknown

2. Tests or Procedures

☐ Abnormal ultrasound. *Specify result/finding:*

_____

Pre-Test counseling. *Check all that apply:*

☐ Serum screen ☐ Amnio ☐ Carrier screen
☐ CVS ☐ Non invasive prenatal screening (NIPS)

Post-Test counseling. *Check all that apply:*

☐ Serum screen ☐ Amnio ☐ Carrier screen
☐ CVS ☐ Non invasive prenatal screening (NIPS)

Other:_____

Patient Documentation - Fax with Referral

4

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

☐ Ultrasound report ☐ Screening results (e.g., First trimester, Quad, AFP)
☐ CVS or Amniocentesis results ☐ Other genetic test results (e.g., CF carrier screen, diagnostic testing)

b. Patient face sheet (Demographics).

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

Provider Information

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_____ 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