InformedDNA®
Genetics, Decoded.

Ocular Genetic Counseling Referral

FORM COMPLETION 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 the following along with this referral form

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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

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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 _____

By submitting this referral form I, the referring provider listed on this form, am (1) requesting my patient receive genetic counseling, and genetic testing if deemed appropriate, by an InformedDNA genetic counselor; and (2) authorizing InformedDNA's genetic counselors to facilitate the completion of any test requisition forms and/or submit any prior authorization, if necessary, on my behalf utilizing my name and NPI. I understand that any genetic testing performed on my patient will be my responsibility and ordered in my name.

Fax completed form to:

6 **760-203-1194**

www.InformedDNA.com

For questions, please call

800-975-4819