InformedDNA®
Genetics, Decoded.

Cancer Genetic Counseling Referral

FORM COMPLETION DATE:___ ___ _____

Patient Information* *(*all fields are required. Mark "No Email" if the patient does not have email.)*

Name:_____ Date of Birth:___ ___ _____

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

Surgery Pending date:___ ___ _____

Language Interpreter Needed?: ☐ Spanish ☐ Other _____

Billing

2 ☐ Bill to Patient Insurance
* In-network only.

☐ Other (Please Explain)_____

Reason for Referral

Personal and/or family history of cancer. List only patient's primary diagnosis, but all family history.

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PATIENT	FAMILY MEMBER		PATIENT	FAMILY MEMBER	
☐	☐	Breast	☐	☐	Melanoma
☐	☐	Ovarian	☐	☐	Thyroid
☐	☐	Colon	☐	☐	Kidney
☐	☐	Rectal	☐	☐	Urinary Bladder
☐	☐	Uterine (corpus uterus)	☐	☐	Urinary - Other
☐	☐	Pancreatic	☐	☐	Other (please specify) _____
☐	☐	Stomach			

Laboratory Information

4 Sample collected ☐ Yes Collection date:___ ___ _____ Sample sent to (Lab name):_____

☐ No Lab preferences (If not already collected):_____

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

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:

7 **760-203-1194**

www.InformedDNA.com

For questions, please call

800-975-4819