



Patient Information

1 Name: _____ Date of Birth: _____
PREFERRED Phone: _____ OTHER Phone: _____ E-mail: _____

Billing

2 Bill to Patient Insurance Other (Please Explain) _____
* In-network only.

Reason for Referral

a. Personal and/or family history of:

Arrhythmia Syndromes:

PATIENT FAMILY MEMBER

- Long QT syndrome
- Brugada syndrome
- Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)

Cardiomyopathies:

PATIENT FAMILY MEMBER

- Arrhythmogenic (ARVC)
- Hypertrophic (HCM)
- Non-ischemic dilated (DCM)
- Restrictive (RCM)

Other:

PATIENT FAMILY MEMBER

- Isolated congenital heart disease
- Familial thoracic aneurysm
- Family history of sudden cardiac death
- Unexplained cardiac arrest (<50 years)
- Known gene mutation in family
- Other: _____

b. Genetic Test Status:

- Test not yet ordered Other: _____
- Test ordered
- Results received Please expedite genetic counseling for immediate management decisions (2-4 business days)
- Unknown

c. Documentation of diagnosis

Please include a clinic note documenting history of disease or suspected diagnosis.

* We will not interpret ECGs, echocardiograms, cardiac MRIs, stress tests, autopsy reports.

Laboratory Information

4 Sample collected Yes No
Collection date: _____ Sample sent to (Lab name): _____
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

5 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

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