



## 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

### Personal and/or Family History (known diagnosis):

- | PATIENT                  | FAMILY MEMBER            |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Duchenne or Becker muscular dystrophy   |
| <input type="checkbox"/> | <input type="checkbox"/> | Myotonic dystrophy (type 1 or 2)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Other muscular dystrophy (i.e. Limb-girdle, Emery Dreifuss)                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Charcot-Marie-Tooth   |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's disease (suspected or known family history, and/or onset <60 years) |
| <input type="checkbox"/> | <input type="checkbox"/> | Parkinson disease (suspected or known family history, and/or onset <50 years)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Frontotemporal dementia (suspected or known family history)                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Amyotrophic lateral sclerosis (suspected or known family history)               |
| <input type="checkbox"/> | <input type="checkbox"/> | Hereditary ataxia   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other neuromuscular, neurodegenerative, or neurometabolic disease               |
| <input type="checkbox"/> | <input type="checkbox"/> | Known gene mutation/neurogenetic condition. Specify: _____                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____  |

### Personal and/or Family History (symptoms):

- | PATIENT                  | FAMILY MEMBER            |                                  |
|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Young-onset dementia (<60 years) |
| <input type="checkbox"/> | <input type="checkbox"/> | Ataxia, non-acquired             |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebellar atrophy               |
| <input type="checkbox"/> | <input type="checkbox"/> | Non-acquired neuropathy          |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____                     |

### Genetic Test Status

- Test not yet ordered  
 Test ordered  
 Results received, please provide results interpretation  
 Unknown  
 Other: \_\_\_\_\_

## Patient Documentation - fax the following along with this referral form

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

- |  |   |
|--|---|
| <input type="checkbox"/> Clinic note outlining history of disease/suspected diagnosis                        | <input type="checkbox"/> Patient genetic test results                               |
| <input type="checkbox"/> Lab/imaging results (i.e. creatine kinase, brain MRI, EMG, and/or muscle biopsy).** | <input type="checkbox"/> Copy of mutation in family (if requesting carrier testing) |

### b. Patient face sheet (demographics).

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

\*\* We will not provide interpretation.

## 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:

6 **760-203-1194**

[www.InformedDNA.com](http://www.InformedDNA.com)

For questions, please call

**800-975-4819**