InformedDNA®
Genetics, Decoded.

Reproductive Genetic Counseling Referral

FORM COMPLETION 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 the following along with this referral form

4

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

☐ Ultrasound report
☐ CVS or Amniocentesis results
☐ Screening results (e.g., First trimester, Quad, AFP)
☐ 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

5

_____ 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