InformedDNA®
Genetics, Decoded.

Cancer Genetic Counseling Referral

FORM FILLING 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 with Referral

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

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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

Fax completed form to:

7 **(760)203-1194**

www.InformedDNA.com

For questions, please call
800-975-4819