InformedDNA Cardiac Genetic Counseling Referral

Genetics, Decoded.

___ /___ /________
Date

Patient Information

1 Name:________________________ Date of Birth:____ /____ /________

Phone:______________ Cell:______________ E-mail:__________________

Billing

2 ☐ Bill to: Dean Health Insurance INC-account #20730

Reason for Referral

3

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
- ☐ Test ordered
- ☐ Results received
- ☐ Unknown
- ☐ Other:______________
- ☐ Please expedite genetic counseling for immediate management decisions (2-4 business days)

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

*Prevea360 policy is that prior authorization is obtained prior to labs being ordered and sent to lab.

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.*

* Used to verify the patient's benefits.

Provider Information

6

____
Medical Center/Practice

____
Practice Contact

____________ ____________
Phone Fax

____
E-mail

____
Address

__________ ______ ______
City State Zip

____
Referring Provider

|_|_|_|_|_|_|_|_|_|_|
NPI

____
Referring Provider's Signature

Fax completed form to:

7 (760) 203-1194

For questions, please call
800-975-4819

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