InformedDNA
Genetics, Decoded.

Neurogenetics Counseling Referral

Date _____

Patient Information

1

Patient Name: _____ Date of Birth:____ /____ /_____

Phone: _____ Cell: _____ E-mail: _____

Insurance – a copy of the patient's insurance card is required* ☐ Please expedite genetic counseling for immediate management decisions (2-4 business days)

Reason for Referral

2

Personal and/or Family History (known diagnosis):

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

Personal and/or Family History (symptoms):

PATIENT	FAMILY MEMBER	
☐	☐	Young-onset dementia (<60 years)
☐	☐	Ataxia, non-acquired
☐	☐	Cerebellar atrophy
☐	☐	Non-acquired neuropathy
☐	☐	Other:_____

Genetic Test Status

- ☐ Test not yet ordered
- ☐ Test ordered
- ☐ Results received, please provide results interpretation
- ☐ Unknown
- ☐ Other:_____

Patient Documentation - Fax with Referral

3

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

- ☐ Clinic note outlining history of disease/suspected diagnosis
- ☐ Lab/imaging results (i.e. creatine kinase, brain MRI, EMG, and/or muscle biopsy).**
- ☐ Genetic test results
- ☐ Copy of mutation in family (if requesting carrier testing)

b. Insurance documentation. ☐ A copy of front and back of the patient's insurance card.

* Used to verify the patient's benefits. | ** We will not provide interpretation

Physician Information

4

_____
Medical Center/Practice

_____
Primary Provider

_____
NPI

_____
Practice Contact

_____ _____
Phone Fax

_____
E-mail

_____
Address

_____ _____ _____
City State Zip

_____
Secondary Provider*

_____
NPI

_____
Referring Physician's Signature

* Will receive copy of Genetic Counseling Summary Report.

Fax completed form to:

5

(760) 203-1194

To refer by phone
800.975.4819

To refer by email
referral@informedDNA.com

www.informedDNA.com