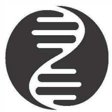

InformedDNA®
Genetics, Decoded.

Reproductive Genetic Counseling Referral

PREVEA360 health plan™

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 Dean Health Insurance INC-account 20730

Reason for Referral

3

1. Personal or Family History

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

I am ordering a genetic counseling consultation and genetic testing if deemed appropriate by the InformedDNA genetic counselor for my patient. I authorize InformedDNA's genetic counselors to facilitate the completion of any test requisition forms, if necessary, on my behalf. 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

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