Genetic Counseling Referral Form

PLEASE NOTE: Rapid and ultra-rapid sequencing post-test counseling referrals should be requested using the Rapid/Ultra Rapid Referral Form. Find it at GeneDx.com/forms.

Fax OR Email completed form to: 201-605-6582 | referral@genedx.com
NOTE: Please submit relevant medical records

Patient Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name (if applicable): _____

Address: _____ Email: _____

Phone Number: _____ ☐ Do NOT Text ☐ No Specimen Collected

Date Specimen Sent to Lab: _____ Specimen ID Number (if applicable): _____

Insurance Information (required for pre-test genetic counseling)

Insurance Company/Policy Name: _____ Policy Number: _____

Group Number: _____ Subscriber Name: _____ Subscriber DOB: _____

ICD10 code: _____

Reason for Referral (Please submit relevant medical records)

☐ Hereditary Cancer ☐ Reproductive Genetics (Post-test counseling only) ☐ Clinical Exome Sequencing

☐ Cardiogenetics ☐ Neurogenetics ☐ Other: _____

Please Indicate All Desired Services

Desired testing laboratory: ☐ GeneDx ☐ Other: _____

☐ Pre-test* & post-test** genetic counseling ☐ Pre-test* genetic counseling only ☐ Post-test** genetic counseling only

*By selecting pre-test counseling, I hereby authorize the genetic counselor to make necessary changes to the order by signing a change in test authorization (CITA) form on my behalf. The genetic counselor will notify me of a test change and I will contact the genetic counselor within 48 hours if I disagree.
**By selecting post-test counseling, I authorize the genetic counselor to receive and provide test results to the patient.

☐ **I do not authorize the genetic counselor to make changes to the pre-test order.**

Authorized Provider

Practice Name: _____ Account #: _____

Phone #: _____ Fax # or Email for Genetic Counseling Summary: _____

In my capacity as my patient's healthcare provider, I hereby authorize the genetic counselor to provide the patient's genetic counseling summary (including medical and family history information) and insurance information/authorization to the designated performing laboratory, as this information is medically necessary for treatment, payment, diagnosis and testing purposes. I have discussed the disclosure of this information with my patient (or the patient's personal representative), who has authorized this disclosure of information for the above-referenced purposes.
In addition to authorization for disclosure, the patient/patient's personal representative has further consented to being contacted via telephone, email or text (Data Rates May Apply) for purposes of scheduling a genetic counseling appointment. I have also informed the patient (or the patient's personal representative) of their right to revoke this consent. Genetic counseling may be performed by a licensed (where applicable by law), third party partner genetics professional not employed by the laboratory or its subsidiaries.

Provider Name: _____ Provider Signature **(REQUIRED)**: _____

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