RAPID AND ULTRARAPID SEQUENCING POST-TEST GENETIC COUNSELING REFERRAL FORM

Fax OR Email completed form to: 301-238-7217 | patientGCsupport@genedx.com

PATIENT INFORMATION			
Name		**Date of Birth**	
Parent/Guardian Name		**Phone Number** *(Mobile preferred)*	
Address		**Email** *(required)*	
Preferred Language		**Accession Number** *(if known)*	

REASON FOR REFERRAL

Post-test genetic counseling, for non-negative results*

**Patients with a negative result will be emailed a negative result education handout. If a patient email is not provided, the negative results handout will be sent to the referring provider to share with the patient.*

- ☐ Rapid Exome Sequencing
- ☐ Rapid Genome Sequencing
- ☐ ultraRapid Genome Sequencing

AUTHORIZED PROVIDER			
Practice Name		**Account #**	
Fax # or email for Genetic Counseling Summary		**Phone Number**	
I hereby authorize the genetic counselor to receive and provide test results to the patient for post-test genetic counseling. 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		**Date**	

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