

PLEASE NOTE: Rapid and ultraRapid sequencing post-test counseling referrals should be requested using the Rapid/ultraRapid Referral Form. Find it at [GeneDx.com/forms](https://www.GeneDx.com/forms).

Fax OR Email completed form to: 201-605-6582 | referral@genedx.com

| PATIENT INFORMATION | | | |
|----------------------|--|---------------------------------------------------|--|
| Name | | Date of Birth | |
| Parent/Guardian Name | | Phone Number <small>(Mobile preferred)</small> | |
| Address | | Email <small>(required)</small> | |
| Preferred Language | | Accession Number <small>(if known)</small> | |

| REASON FOR REFERRAL | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Post-test genetic counseling, for non-negative results* <small>*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.</small> <input type="checkbox"/> Exome Sequencing <input type="checkbox"/> Genome Sequencing <input type="checkbox"/> Other: _____ | |

| 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 | |