InformedDNA®
Genetics, Decoded.

Genetic Services Program

Neurogenetics Counseling Referral

DeanHealthPlan
A member of SSM Health

FORM COMPLETION DATE: ___ ___ _____

Patient Information

1

Name:_____ Date of Birth:___ ___ _____

PREFERRED Phone:_____ OTHER Phone:_____ E-mail:_____

Billing

2

☐ Bill to Dean Health Insurance INC-account 20730

Reason for Referral

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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 the following along with this referral form

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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).**
- ☐ Patient genetic test results
- ☐ Copy of mutation in family (if requesting carrier testing)

b. Patient face sheet (demographics).

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

** We will not provide interpretation.

Provider Information

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Medical Center/Practice _____ Practice Contact _____

Phone _____ Fax _____ E-mail _____

Address _____ City _____ State _____ Zip _____

Referring Provider _____ Fax *(required)* _____

NPI _____ Referring Provider's Signature _____

By submitting this referral form I, the referring provider listed on this form, am (1) requesting my patient receive genetic counseling, and genetic testing if deemed appropriate, by an InformedDNA genetic counselor; and (2) authorizing InformedDNA's genetic counselors to facilitate the completion of any test requisition forms and/or submit any prior authorization, if necessary, on my behalf utilizing my name and NPI. I understand that any genetic testing performed on my patient will be my responsibility and ordered in my name.

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Fax completed form to:
760-308-6324
Fax EXPEDITED form to:
760-501-8522

QUESTIONS? PLEASE CALL **888-308-1095**

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