InformedDNA®
Genetics, Decoded.

Cancer Genetic Counseling Referral

DeanHealthPlan
A member of SSM Health

FORM COMPLETION DATE:___ ___ _____

Patient Information* *(*all fields are required. Mark "No Email" if the patient does not have email.)*

Name:_____ Date of Birth:___ ___ _____

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

Surgery Pending date:___ ___ _____

Language Interpreter Needed?: ☐ Spanish ☐ Other _____

Billing

2 ☐ Bill to Dean Health Insurance INC-account 20730

Reason for Referral

Personal and/or family history of cancer. List only patient's primary diagnosis, but all family history.

3

PATIENT	FAMILY MEMBER		PATIENT	FAMILY MEMBER	
☐	☐	Breast	☐	☐	Melanoma
☐	☐	Ovarian	☐	☐	Thyroid
☐	☐	Colon	☐	☐	Kidney
☐	☐	Rectal	☐	☐	Urinary Bladder
☐	☐	Uterine (corpus uterus)	☐	☐	Urinary - Other
☐	☐	Pancreatic	☐	☐	Other (please specify) _____
☐	☐	Stomach			

Laboratory Information

4 Sample collected ☐ Yes Collection date:___ ___ _____ Sample sent to (Lab name):_____

☐ No Lab preferences (If not already collected):_____

InformedDNA considers test quality, cost, and physician preference when selecting a laboratory.

Patient Documentation - fax the following along with this referral form

5

a. Clinical. Please include the following (if performed) ☐ Pathology reports ☐ Patient genetic test results ☐ Family member genetic test results ☐ Test request form **IF SAMPLE COLLECTED**

b. Patient face sheet (demographics).

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

Provider Information

6

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:

7 **760-203-1194**

www.InformedDNA.com

For questions, please call

800-975-4819