InformedDNA
Genetics, Decoded.

Reproductive Genetic Counseling Referral

DeanHealthPlan
A member of SSM Health

FORM COMPLETION DATE:___ ___ _____

Patient Information

1

Name:_____ Date of Birth:___ ___ _____

PREFERRED Phone:_____ OTHER Phone:_____

☐ Please expedite genetic counseling for immediate management decisions (2-4 business days)

Billing

2

☐ Bill to Dean Health Insurance INC-account 20730

Reason for Referral

1. Personal or Family History

3

PATIENT/ PARTNER	FAMILY MEMBER	
☐		Maternal age ≥ 35
☐		Paternal age >/= to 40
☐	☐	≥ 2 miscarriages
☐	☐	Pregnancy loss beyond 20 weeks gestation (stillbirth)
☐	☐	Birth defect. *Specify:*_____
☐	☐	Intellectual disability (e.g., developmental delay, autism)
☐	☐	Chromosome abnormality. *Specify:*_____
☐	☐	Diagnosis of a known genetic disorder. *Specify:*_____
☐	☐	Carrier of a known genetic disorder. *Specify:*_____
☐		Azoospermia/oligospermia
☐		Congenital absence of the vas deferens
☐	☐	Premature ovarian failure

Patient and partner are blood relatives (consanguinity)

☐ Yes ☐ No ☐ Unknown

2. Tests or Procedures

☐ Abnormal ultrasound. *Specify result/finding:*

_____

Pre-Test counseling. *Check all that apply:*

☐ Serum screen ☐ Amnio ☐ Carrier screen
☐ CVS ☐ Non invasive prenatal screening (NIPS)

Post-Test counseling. *Check all that apply:*

☐ Serum screen ☐ Amnio ☐ Carrier screen
☐ CVS ☐ Non invasive prenatal screening (NIPS)

Other:_____

Patient Documentation - fax the following along with this referral form

4

a. Clinical. Please include the following (if performed)

☐ Ultrasound report ☐ Screening results (e.g., First trimester, Quad, AFP)
☐ CVS or Amniocentesis results ☐ Other genetic test results (e.g., CF carrier screen, diagnostic testing)

b. Patient face sheet (demographics).

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

Provider Information

5

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:

6 **760-203-1194**

www.InformedDNA.com

For questions, please call

800-975-4819