Genetic Support Foundation

National Telehealth Genetic Counseling
Call us with questions at 360-485-0115

Genetic Counseling Referral Form

Please fax this form, along with all relevant clinic notes and labs/pathology results to 844-813-3892

Date: Priority: Routine ☐ Urgent ☐

Patient Information:

Name: ______________________________________

DOB: __________________ Sex:____________

Address: _____________________________________

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Phone: ______________________________________

Email: ______________________________________

Language *(if interpreter needed)*:__________________

Referring Provider:

Name: _______________________________________

Clinic Address: ________________________________

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Phone: _______________________________________

Fax: ____

Primary Care Provider *(if different than referring)*:

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Reason for Referral:

- ❏ Cancer (breast, ovarian, colon, prostate, etc.)
- ❏ Cardiac (sudden death, cardiomyopathy, etc.)
- ❏ Neurological (epilepsy, Huntington, etc.)
- ❏ Preconception/Prenatal (NIPS, PGT, etc.)
- ❏ Review genetic test result (family variant, DTC, etc)
- ❏ Newborn screening (confirmatory testing, etc.)
- ❏ Genetic syndrome and/or disorder
  - ❏ Autism/Intellectual disability
  - ❏ Connective tissue (EDS,Marfan,etc.)
  - ❏ Hearing or vision loss
  - ❏ Muscular dystrophy
  - ❏ Unexplained congenital anomalies
- ❏ Other: ___________________________________

Please Provide Specifics: *(relation to patient, age of onset, diagnosis, prior genetic testing, etc.)*

☐ Personal history of: ☐ Family history of:

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Genetic testing may require a co-signature by a provider, depending on state guidelines. By signing this form you consent to be the ordering provider on any genetic testing that is ordered. All pre- and post-test genetic counseling will be performed by the genetic counselor, and you will receive copies of any genetic testing results.

Provider Signature: ____ Date: __________________