Genetic Support Foundation

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

Genetic Counseling Neurology 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: _____

_____

Phone: _____

Email: _____

Language *(if interpreter needed)*:_____

Referring Provider:

Name: _____

Clinic Address: _____

_____

Phone: _____

Fax: _____

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

_____

Reason for Referral:

- ❑ **Neurodegenerative disorders**, e.g., Huntington disease, early-onset (<65 yo) Alzheimer's disease, frontotemporal dementia
- ❑ **Neuromuscular disorders**, e.g., amyotrophic lateral sclerosis, muscular dystrophies, myotonic dystrophy, spinal muscular atrophy
- ❑ **Neuropathies**, e.g., Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies
- ❑ **Neurodevelopmental disorders**, e.g., developmental delay, intellectual disability, autism spectrum disorder
- ❑ **Ataxias**, e.g., e.g., Friedreich ataxia, spinocerebellar ataxia, fragile X tremor/ataxia, ataxia-telangiectasia
- ❑ **Epilepsy**, e.g., isolated or syndromic epilepsy
- ❑ **Genetic test result:** _____
- ❑ **Other potentially inherited neurological condition**: _____

Genetic Testing Status:

- ❑ Genetic testing not yet ordered
- ❑ Genetic testing ordered - results pending
- ❑ Genetic testing ordered - results received

Genetic Counseling Service Requested:

- ❑ Patient is symptomatic (evaluated by a neurologist)
- ❑ Family history of neurological condition
- ❑ Dicusssion of genetic test results

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: _____