InformedDNA
Genetics, Decoded.

Cardiac Genetic Counseling Referral

WellFirst 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

a. Personal and/or family history of:

3

Arrhythmia Syndromes:

PATIENT / FAMILY MEMBER

- ☐ ☐ Long QT syndrome
- ☐ ☐ Brugada syndrome
- ☐ ☐ Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)

Cardiomyopathies:

PATIENT / FAMILY MEMBER

- ☐ ☐ Arrhythmogenic (ARVC)
- ☐ ☐ Hypertrophic (HCM)
- ☐ ☐ Non-ischemic dilated (DCM)
- ☐ ☐ Restrictive (RCM)

Other:

PATIENT / FAMILY MEMBER

- ☐ ☐ Isolated congenital heart disease
- ☐ ☐ Familial thoracic aneurysm
- ☐ ☐ Family history of sudden cardiac death
- ☐ ☐ Unexplained cardiac arrest (<50 years)
- ☐ ☐ Known gene mutation in family
- ☐ ☐ Other:_____

b. Genetic Test Status:

- ☐ Test not yet ordered
- ☐ Test ordered
- ☐ Results received
- ☐ Unknown
- ☐ Other:_____
- ☐ Please expedite genetic counseling for immediate management decisions (2-4 business days)

c. Documentation of diagnosis

Please include a clinic note documenting history of disease or suspected diagnosis.

* We will not interpret ECGs, echocardiograms, cardiac MRIs, stress tests, autopsy reports.

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

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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

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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 _____

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