InformedDNA®
Genetics, Decoded.

# Cancer Genetic Counseling Referral

PREVEA360 health plan℠

FORM COMPLETION DATE:___ ___ _____

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

1

Name:_____ Date of Birth:___ ___ _____

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.

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| 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

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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**