InformedDNA®
Genetics, Decoded.

POST TEST Genetic Counseling Referral

bio GX Laboratory

Date _____

Patient Information

Name: _____ Date of Birth: _____

Preferred Phone: _____ Other Phone: _____ Email: _____

Billing

Account #20782 for BIOGx Laboratory

Reason for Referral

Post-test genetic counseling for the following genetic testing types. Please check one to ensure scheduling with the appropriate genetics specialist.

- ☐ cancer
- ☑ pharmacogenomic
- ☐ pediatric (e.g. whole exome sequencing and chromosome microarray)
- ☐ reproductive (e.g. carrier screening, NIPS, chromosome microarray)
- ☐ ocular
- ☐ neurology
- ☐ cancer
- ☐ other:_____

Patient Documentation - Fax with Referral

a. **Test Results (required)**

b. **This form must be signed by the Referring Provider**

c. **Patient Face Sheet or Demographics (if available)**

Physician Information

_____
Medical Center/Practice

_____
Referring Provider

_____
NPI

_____ _____
Phone **Fax**

_____
Email

_____
Address

_____
City

_____ _____
State **Zip**

_____
Referring Provider's Signature

*Will receive copy of Genetic Counseling Summary report

Fax completed form to:

(813) 940-7445

For Questions, please call **800-975-4819**

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