Genetic Counseling Referral Form

BioReference® LABORATORIES | genpath®
OPKO Health Companies

Fax completed form to: 201-918-3986
Or Email: GCreferral@bioreference.com

NOTE: Please submit relevant medical records and insurance information.

Genetic counseling is a valuable part of patient care and can help patients understand the benefits and limitations of genetic testing. Some commercial insurances require pre-test genetic counseling from an independent genetic counselor as a condition of coverage for genetic testing. Complete this referral form if you wish your patient to receive genetic counseling.

Patient Information

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________ Email: ______________

Phone Number: ______________ ☐ Ok to text | ☐ No specimen collected Date specimen sent to lab: ______________

Specimen ID number (if applicable): ______________ ICD10 **(REQUIRED)**: ______________

Insurance Information

Insurance Company/Policy Name: ______________ Policy Number: ______________

Group Number: ______________ Subscriber Name: ______________ Subscriber Date of Birth: ______________

Reason for Referral *(Please submit relevant medical records and insurance information.)*

☐ Hereditary Cancer ☐ Reproductive Genetics (Post-test counseling only)

Please Indicate All Desired Services

☐ **Pre-test* and post-test** genetic counseling** ☐ **Pre-test* genetic counseling only** ☐ **Post-test** genetic counseling only**

*By selecting pre-test counseling, I hereby authorize the genetic counselor to make necessary changes to the test order by signing a change in test authorization (CITA) form on my and the laboratory's behalf. The genetic counselor will notify me of a test change and I will contact the genetic counselor within 48 hours if I disagree.

**By selecting post-test counseling, I authorize the genetic counselor to receive and provide test results to the patient.

☐ **I do not authorize the genetic counselor to make changes to the pre-test order.**

Authorized Provider

GenPath® Account #: ______________ Copy to: GCreferral@Bioreference.com

Practice Name: ______________ Copy to Account #: ZA158

Phone #: ______________ Fax #: ______________

In my capacity as my patient's healthcare provider, I hereby authorize the genetic counselor to provide the patient's genetic counseling summary (including medical and family history information) and insurance information/authorization to the designated performing laboratory, as this information is medically necessary for treatment, payment, diagnosis and testing purposes. I have discussed the disclosure of this information with my patient (or the patient's personal representative), who has authorized this disclosure of information for the above-referenced purposes.

In addition to authorization for disclosure, the patient/patient's personal representative has further consented to being contacted via telephone, email or text (Data Rates May Apply) for purposes of scheduling a genetic counseling appointment. I have also informed the patient (or the patient's personal representative) of their right to revoke this consent. Pursuant to the patient's insurance policy, genetic counseling may be performed by a licensed (where applicable by law), independent genetics professional not employed by the laboratory or its subsidiaries.

Provider Name: ______________ Provider Signature **(REQUIRED)**: ______________

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