Genetic Counseling Referral Form

BioReference® | GenPath®

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 education and/or counseling.

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

Accession Number (If available): _____ ICD-10 **(Required)**: _____

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

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

Please Indicate the Desired Service

☐ OnkoRisk™ Pre-test genetic education and/or counseling (TQ06-1)

☐ OnkoRisk™ Post-test genetic education and/or counseling (TQ07-9)

☐ Reproductive Post-test results counseling

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

Authorized Provider

Client Account #: _____ Phone #: _____

Practice Name: _____ Fax #: _____

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

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☐ _____ ☐ _____

☐ _____ ☐ _____

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. I have also informed the patient (or the patient's personal representative) of their right to revoke this consent.

Provider Signature **(Required)**: _____