FERRE GENETICS

Administrative office – 124 Front St, Binghamton, NY 13905
Phone – 607-724-4308 • Fax – 607-724-8290

Southern Tier • Mohawk Valley • Capital District • North Country

Genetics Referral Form

Date of referral:_____

Patient Name: _____ DOB: _____
First *Last*

Patient Phone: (____) _____ Alternate Phone: (____) _____

Indication for Genetic Counseling Referral:_____

_____

ICD-10 Code(s):_____

Referring Provider:_____ Contact person: _____

Complete Address:_____

Phone: (____) _____ Fax: (____) _____

By submitting this referral, I agree that appropriate testing may be ordered for this patient in my name and this document will serve as the test order. I understand that I will receive a copy of all results.

Provider Signature:_____ NPI:_____

Please fax this referral form along with the following to (607) 724-8290

- Patient demographic form with complete address and phone number
- Insurance information – legible copy of card preferred
- Pertinent medical records
  - most recent evaluation summary or clinic note
  - all prior genetic testing reports - chromosome analysis, hemoglobin electrophoresis, carrier screening, single gene or panel gene test reports
  - cancer cases - pathology report
  - obstetrical cases - prenatal record, ultrasound reports, maternal serum screen results, most recent CBC
- Completed letter of medical necessity, if indicated

Once we have received the above information, it will be reviewed by our genetic counselors and, if appropriate, we will contact your patient to offer them a genetic counseling appointment.

PT ID# _____
(Office use only)
Revised 9/2019