AFFILIATION (INTERNAL USE ONLY):
Houston-Methodist-PCG

Genetic Services
REFERRAL FORM

Patient Information (ALL FIELDS REQUIRED)

Patient Name: _____ Patient DOB: _____

Date of Referral: _____

Requested Service: ☐ Pre-Test Counseling ☐ Post-Test Counseling

Specific Reason for Referral*: _____

Please see page 2 for additional information regarding referral

☐ Patient is Under 18 Years of Age

Parent or Guardian Name (if patient is < years of age): _____

Physician Information (ALL FIELDS REQUIRED)

Practice Name: _____ Referring Provider: _____ NPI: _____

Address: _____ City, State and Zip: _____

Phone: _____

NOTE:

Visit/result summaries will be sent to HMHRecordProcessing@houstonmethodist.org and uploaded to the media tab in the patient's chart after which providers will receive a notification in their basket.

Submit this completed form and the patient's registration face sheet* to:

*Retrieve the Registration Face Sheet by going to Registration > More (top right corner) > Print Forms > print HM REG CLINIC FACE SHEET.

EMAIL: **REFERRALS@GENOMEMEDICAL.COM** or FAX: **856-961-5323**

Upon receipt of the following form, Genome Medical will contact your patient by email.
Questions? You can reach us via chat/email at www.genomemedical.com or phone 877-688-0992

Patient Name:_____ Patient DOB:_____

The information on this page is to help our clinical staff connect your patient with the most appropriate genetic clinician depending on the referral reasoning. Please fill out the following to the best of your ability. Thank you!

Please complete if your patient is a **CANCER REFERRALS**

Reason for Referral (Check all that apply, select P if personal history and F if family history):

- ☐ Breast Cancer (☐P/ ☐F)
- ☐ Ovarian Cancer (☐P/ ☐F)
- ☐ Pancreas Cancer (☐P/ ☐F)
- ☐ Met. Prostate Cancer (☐P/ ☐F)
- ☐ Colon Cancer (☐P/ ☐F)
- ☐ Uterine Cancer (☐P/ ☐F)
- ☐ Other Type (☐P/ ☐F)

_____

_____

Please provide any additional information relevant to the referral:

_____

PRENATAL/REPRODUCTIVE REFERRALS

Pregnant: Y☐/ N☐ if yes EDD: _____

Reason for referral:

- ☐ Genetic screening and options discussion
- ☐ Advanced maternal age (>35 singleton/>33 twins)
- ☐ Advanced paternal age (>40)
- ☐ Abnormal test results (please include a copy of results)
- ☐ Abnormal ultrasound findings
- ☐ Personal or family history of birth defects/genetic syndrome
- ☐ History of multiple miscarriages or unexplained infant deaths
- ☐ History of unexplained infertility
- ☐ Consanguinity
- ☐ Maternal exposures in pregnancy (i.e medications/illicit drugs)

Please provide any additional information relevant to the referral:

_____

PEDIATRICS/GENERAL ADULT GENETICS REFERRALS

Reason for referral:

- ☐ Personal or family history of a known genetic condition
- ☐ Specific indication (check all that apply)
  - ☐ Developmental delay
  - ☐ Autism spectrum disorder
  - ☐ Multiple congenital anomalies/birth defects
  - ☐ Neurological problems (eg muscle weakness, seizures)
  - ☐ Growth concerns (eg failure to thrive, overgrowth)
  - ☐ Metabolic issues
  - ☐ Other

Please provide any additional information relevant to the referral:

_____

_____

CARDIOLOGY REFERRALS

Reason for referral:

- ☐ Positive genetic testing in the family
- ☐ Hypertrophic cardiomyopathy (☐P/ ☐F)
- ☐ Dilated cardiomyopathy (☐P/ ☐F)
- ☐ Other cardiomyopathy (☐P/ ☐F)
- ☐ Aortic aneurysm/dissection or concern for related condition (eg Marfan syndrome) (☐P/ ☐F)
- ☐ Long QT syndrome (☐P/ ☐F)
- ☐ Other arrhythmia (☐P/ ☐F)
- ☐ Sudden cardiac arrest/death (☐P/ ☐F)
- ☐ Congenital heart defect (☐P/ ☐F)
- ☐ Lipid disorder/familial hypercholesterolemia (☐P/ ☐F)
- ☐ Other

Please provide any additional information relevant to the referral:

_____

PHARMACOGENOMIC REFERRAL

Please list all medication:

_____ _____ _____

_____ _____ _____

Please provide any additional information relevant to the referral:

_____