

### Genetic Counseling Referral Form

**Test Type**  Carrier Screening  Hereditary Cancer Screening  PGT-A

**Session Type**  Pre-Test  Post-Test

#### Patient Information

Patient First Name \_\_\_\_\_ Patient Last Name \_\_\_\_\_  
 Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone Number \_\_\_\_\_  
 E-mail \_\_\_\_\_ Is language interpreter needed?  Language \_\_\_\_\_  
 Location of Patient: State \_\_\_\_\_ Time Zone \_\_\_\_\_

#### Referral Provider Information

Provider Name \_\_\_\_\_ Clinic Name \_\_\_\_\_  
 Referring Provider Signature \_\_\_\_\_ Date Signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

#### New Providers Only (Please Complete Fields Below)

NPI \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Fax \_\_\_\_\_ Office Contact \_\_\_\_\_  
 Email \_\_\_\_\_

#### Genetic Counseling Process



**1**

Provider completes referral form



**2**

Provider faxes or e-mails referral form and any pertinent patient medical records (test results, cancer history form, etc.) to Metis Genetics



**3**

Metis Genetics will contact the patient to schedule a counseling session within 48 hours of receiving the completed referral form



**4**

After the counseling session, a summary report will be sent to the referring provider within 48 hours