Ferre Institute, Inc.

COMPREHENSIVE COMMUNITY BASED GENETIC SERVICES

Phone: 1-888-48-FERRE (3-3773)

GENETIC COUNSELING PROGRAM
124 Front Street
Binghamton, NY 13905

MOHAWK VALLEY GENETIC SERVICES
4 Oxford Crossing
New Hartford, NY 13413

NORTH COUNTRY GENETICS SERVICE
Potsdam, NY 13676

CAPITAL DISTRICT ADULT GENETICS PROGRAM
Albany, NY

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GENETICS REFERRAL FORM

Genetic Counseling Location: □ **Binghamton** □ **Mohawk Valley** □ **North Country** □ **Capital District** □ **Arnot**

Referring Physician:_____ Contact person: _____ Date of referral:_____

Complete Address:_____

Phone:_____ Fax: _____ ***Please include area code***

Patient Name: _____ DOB: _____
Last ***First***

Complete Address: _____
Address ***City*** ***State*** ***Zip code***

Home Phone: _____ Work Phone: _____ extension# _____ ***Please include area code***

Parent/Guardian Name: _____

Insurance Name: _____ Subscriber's Name: _____

Insurance ID#: _____ Group #:_____

□ **Preauthorization for Out-of-Network Required?** □ **Yes** ■ **No**
Preauthorization #: _____

MUST BE COMPLETED - Indication for Genetic Counseling Referral:

▣ **Prenatal: Indication -** _____ **EDC:** _____

■ **Cancer: Type of cancer - Personal -** _____

Family- _____

■ **Other (Pediatric, Cardiovascular, etc…) - Indication:** _____

_____

PLEASE FAX TO (607) 724-8290 :

- ☐ **a copy of the patient's insurance card**
- □ **competed referral form**
- □ **completed letter of medical necessity**

PERTINENT MEDICAL RECORDS TO SUPPORT INDICATION:

- □ **obstetrical records such as: prenatal record, sonograms, maternal serum screen results, most recent CBC, etc…**
  IMPORTANT PLEASE INCLUDE CARRIER TESTING REPORTS such as: hemoglobin electrophoresis, Cystic Fibrosis, Fragile X, Chromosome Analysis, etc…
- □ **pathology; surgical reports; laboratory; mammogram; MRI;**
- □ **evaluation summary**
- □ **history & physical**

PT ID# _____
(Office use only)
Revised 1/2014

Diane M. Preston
Clinical Case Coordinator

Lisa M. Behr
Case Coordinator