Genetic Request Form

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The Smith Family CLINIC for GENOMIC MEDICINE®

www.smithfamilyclinic.org

Date: _____

Physician/Healthcare Provider: _____

Specialty: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Patient Name: _____

Date of Birth: _____ / _____ / _____

Parent/Legal Guardian Name: _____

Patient Primary Phone Number: _____

Patient Secondary Number: _____

The Smith Family Clinic for Genomic Medicine notes and test results will be sent to the referring provider upon conclusion of testing and care.

Primary Insurance: _____ Policy Holder Name: _____

Secondary Insurance: _____ Policy Holder Name: _____

Please send all relevant documentation/specialist notes and results of any prior genetic testing with this completed form.

Reason for Consultation: _____

Physician Signature: _____ **Date:** _____