



Post-Test Genetic Counseling Referral Form | Oncology

For positive and/or VUS results only

Referral Source

REFERRING PROVIDER		FORM COMPLETED BY	
MEDICAL CENTER/PRACTICE		OFFICE PHONE	
		OFFICE FAX	
<p>Confirmation of informed consent: The undersigned person (or representative thereof) ensures that the patient has given appropriate informed consent for post-test genetic counseling by an and/or third-party genetic counselor, and authorizes Tesis Biosciences to release medical information concerning the patient's testing and family/medical history to said genetic counselor. I understand that the referred genetic counselor is not a physician. The patient will be advised to follow up with their physician or other healthcare provider for medical advice, including the diagnosis of any condition and the recommendations for medical management related to their diagnosis and/or family history.</p>			
REFERRING PROVIDER SIGNATURE (REQUIRED)		DATE	

Patient Information

NAME		DATE OF BIRTH	
MOBILE PHONE	HOME PHONE	EMAIL (IMPORTANT FOR ONLINE SCHEDULING)	
STATE OF RESIDENCE/STATE AT TIME OF APPOINTMENT		PRIMARY LANGUAGE IF NON-ENGLISH SPEAKING	

Reason for Referral (Please do not send form before results have been reported):

- Urgent referral (Surgery pending)
- Further education and discussion (Results already disclosed)
- Initial results disclosure (Patient not aware of results)

Please provide any pertinent referral information below:

Please fax completed form and consultation note/family history to Phone: 713-271-4133 or email to GeneticCounseling@tesisbiosciences.com

For questions about this form or Tesis's Genetic Counseling Services, please email GeneticCounseling@tesisbiosciences.com