TriHealth

Precision Medicine

Cardiovascular Genetic Counseling Referral Form

Phone 513-853-4363 to reach a scheduler or genetic counselor with any questions

FAX form to TriHealth Genetic Counseling at **513-852-8508**

Patient Name:_____DOB: _____

Patient Phone Number: _____

Ordering Provider _____ Provider Phone Number _____

Physician/Authorized Healthcare Provider signature required for referral

Signature: _____ Date: _____

Reason for Referral (ADULT indications only):

- ☐ *Known mutation* in the following gene in the family: _____
- ☐ Hypertrophic Cardiomyopathy (personal or family history)
- ☐ I*diopathic* Dilated Cardiomyopathy (personal or family history)
- ☐ Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy (personal or family history)
- ☐ Familial Amyloidosis (Hereditary Transthyretin Amyloidosis) (personal or family history)
- ☐ Thoracic aortic aneurysm/dissection (personal or family history)
- ☐ Marfan syndrome (personal or family history)
- ☐ Loeys-Dietz syndrome (personal or family history)
- ☐ *Vascular* Ehlers-Danlos syndrome (personal or family history)
- ☐ Long QT syndrome (personal or family history)
- ☐ Brugada syndrome type 1 (personal or family history)
- ☐ Sudden cardiac arrest (personal or family history)
- ☐ Sudden cardiac death
- ☐ Familial Hypercholesterolemia (FH) or another dyslipidemia (personal or family history)
- ☐ Heritable heart defect (**ADULT**)

Other Personal or Family History: _____

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