# Neurology/Adult Genetic Counseling Referral Form

Phone 513-853-4363 to reach our department with any questions

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

(Referrals can also be made in Epic AMB REFERRAL TO ADULT GENETIC COUNSELING (NON ONC)[REF2224])

Patient Name: _____ DOB: _____

Patient Phone Number: _____

Patient E-mail: _____

Ordering Physician: _____

Form Completed By: _____

Patient is being referred for genetic risk assessment, coordination of genetic testing, and/or interpretation of genetic test results.

**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: _____
- Neurology
- Hematology
- Family Planning/Preconception
- Other, please specify _____

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