Referral Form
Pediatric Genetics

Scheduling Line: 909-651-1899
Fax: 909-651-1770

Patient Information	
Does this patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship: ____________________	
Patient Name:	Date of Birth:
Parent/Guardian:	Parent/Guardian Phone:
Insurance:	Home Phone:

1. Please select the type of referral: ☐ STAT ☐ Urgent ☐ Routine

If Stat or Urgent, please call our doctor-to-doctor line (909) 558-0099

2. Is this referral for a second opinion? ☐ No ☐ Yes

3. What is the key question you want us to answer? ____

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To optimize appointment scheduling, please provide the following by FAX to 909-651-1770

- This completed form
- A copy of the patient's insurance card
- If authorization is required, was authorization submitted? ☐ Yes ☐ No ☐ Not Applicable
- Any of the following that have been completed:
  - ☐ Chromosome analysis
  - ☐ Chromosome microarray analysis
  - ☐ Fragile X syndrome DNA analysis
  - ☐ Result of genetic testing documenting the diagnosis for which referred
  - ☐ Result of genetic testing in family member pertinent to the reason for referral
  - ☐ Parental f/u testing for VUS on microarray
  - ☐ Echocardiogram report
  - ☐ Ophthalmology exam consult note
  - ☐ Audiology consult note
  - ☐ Hospital discharge summary (NICU, PICU, Other)
  - ☐ Peds Specialist consult note
  - ☐ Pediatric skeletal dysplasia survey report. Family to provide us with a copy of the X-ray images on a CD

Referring Provider Information

Provider Name:	OR Provider Stamp
Address:	
City, State, Zip:	
Phone:	
Fax:	
***Please notify the patient to call our Scheduling Line to make an appointment: 909-651-1899.**	