EMORY CLINIC

**Division of Medical Genetics**
1365 Clifton Road, NE – Building B, Suite 2200 - Atlanta, GA 30322
Phone 404-778-8570 – Fax 404-778-8562

# New Patient Referral and Supporting Documentation

*Please, complete the below form and return using the above contact information, attention Emory Human Genetics.*

****All fields are required unless otherwise noted****

_____
**Date**

## Patient Information

_____ _____
**Last Name** **First Name**

_____ _____ _____
**Date of Birth** **Gender** **Primary Language**

_____ _____ _____
**Primary Number** **Secondary Number** *(optional)* **E-mail Address** *(optional)*

_____
**Address - Street, City, State, and Zip**

_____
**For Patients Under 18: Name and Relationship of Guardian(s)** *(Adult patients with a guardian, please explain)*

## Insurance Cardholder Information

*Attach a copy of the insurance card. If the patient is the cardholder, you can write "same" in applicable fields.*

*For Kaiser, Tricare, and other insurances that require an authorization, we require the authorization before we can schedule. Please, send that authorization with your referral.*

_____ _____
**Last Name** **First Name**

_____ _____ _____
**Date of Birth** **Gender** **Relationship to Patient (or Self)**

_____ _____
**Name of Insurance Carrier** **Address for Claims - Street, City, State, and Zip**

_____ _____
**Subscriber ID** **Group ID**

# Additional Resources on Specific Conditions

*Below are some additional resources on specific conditions to guide you and your patient:*

- Cancer Genetics for Minors – We only see adults for cancer-related genetic concerns. Pediatric patients should see Children's AFLAC Cancer Predisposition Clinic: P) 404-785-1112 -- F) 404-785-9111

- Carrier Testing – We do not order individual carrier testing and we do not see patients who are ONLY carriers of disorders, and therefore not affected (i.e. cystic fibrosis carrier, sickle cell disease carrier, etc.). If patients are *symptomatic* and need testing to rule out or rule in a condition, we would be glad to see them.

- Ehlers-Danlos Syndrome, hypermobility, connective tissue disorders, joint laxity, joint pain – In order to provide further testing and counseling, we require the following:
  1. Personal or family genetic testing that shows a likely pathogenic or pathogenic variant;
  2. Personal or family history of spontaneous organ or tendon ruptures not related to patient age or injury; OR
  3. Aneurysm or arterial dissection, aortic dilatation confirmed by echocardiogram

- MTHFR Mutation – In order to provide further testing and counseling, we require the following:
  1. Testing that shows elevated homocysteine levels; AND
  2. Genetic testing that shows homozygous C677T variants

- Preconception Screening – We refer preconception screening to the genetic counselors with Emory's maternal fetal medicine team. This includes miscarriages, infertility, and current pregnancies where the unborn child is at risk. Reach out to them at P) 404-778-3401 and F) 404-686-1652.

# Referring Physician Information

_____ _____

**Name** **Practice Name**

_____ _____ _____

**Office Phone** **Fax** **E-mail Address** *(optional)*

# Primary Physician Information

_____ _____

**Name** **Practice Name**

_____ _____ _____

**Office Phone** **Fax** **E-mail Address** *(optional)*

***Department of Human Genetics - New Patient Referral and Supporting Documentation***

Patient Name & DOB: _____

# Referral Information

*If your patient needs immediate care, call 404-785-6000 and ask for the Geneticist On-Call*

| | **Diagnosis and Symptoms** (Mark All That Apply) | **Clinical Documentation Required** ***Please, send these documents as part of the referral*** | | |
|---|---|---|---|---|
| | | **Clinic Notes** *(always required)* | **Growth Charts** | **Labs or Specialty Notes** |
| | Abnormal Labs | Yes | | A copy of the abnormal labs |
| | Abnormal Genetic Tests | Yes | Yes | A copy of the abnormal genetic tests |
| | Abnormal Pigmentation | Yes | | |
| | Aortic Abnormalities | Yes | | Echocardiogram |
| | Autism | Yes | | Autism Evaluation |
| | Congenital Anomalies | Yes | | |
| | Down Syndrome | Yes | | Karyotype Testing or Other Genetic Testing |
| | Developmental Delays | Yes | | |
| | Dysmorphic Features | Yes | | |
| | Failure to Thrive | Yes | Yes | |
| | Fragile X | Yes | | Karyotype Testing or Other Genetic Testing |
| | Frequent Fractures | Yes | | X-Rays and Relevant Labs |
| | Hearing Loss | Yes | | Hearing Evaluation |
| | Hypotonia | Yes | | |
| | Intellectual Disability | Yes | | |
| | Macro/Micro-cephaly | Yes | Head Circum. | |
| | Marfan's | Yes | | Echocardiogram |
| | Metabolic Disorders | Yes | Yes | Relevant Labs |
| | Mitochondrial Disorders | Yes | | Relevant Labs |
| | Obesity | Yes | Yes | |
| | Regression | Yes | Head Circum. | |
| | Seizures | Yes | | Neurological Eval |
| | Skeletal Disorders, e.g.:<br>*- Achondroplasia*<br>*- Osteogenesis Imperfecta*<br>*- Short/Tall Stature* | Yes | Yes for Short/Tall Stature | OI and Achondroplasia need X-Rays<br>OI also needs a Dexa Scan |
| | Vascular Anomalies | Yes | | |

*Anything not on this list, please send a separate note with the diagnosis/symptoms, clinic notes, and relevant testing.*