Ambry Genetics®

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	

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 Ambry Genetics and/or third-party genetic counselor, and authorizes Ambry Genetics 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.

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 949-607-2861
or email to GeneticCounseling@ambrygen.com

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

One Enterprise, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 **ambrygen.com**

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