EMORY CLINIC

Department of Human Genetics
404 778 8570 FAX 404 778 8562

NEW PATIENT REFERRAL
AND SUPPORTING DOCUMENTATION***

DATE__________________

*** Required Information**

___________________________________ ________________________________
***PATIENT'S FULL LAST NAME** ***FIRST NAME**

***DOB ______/_______/______** **Gender : F / M**

***Patient/Parent/Guardian Contact Information:**

___________________________________ ________________________________
***FULL LAST NAME** ***FIRST NAME**

***Home Phone (________) ______________________ Alt. # (_________) ______________________**

***Street Address____**

***City ____________________________ *State _____ *ZIP Code _____________**

E-Mail address _________________________________

***Primary Language ___________________** ***Interpreter needed Yes No**

***Reason for Referral ____**

____

***Urgency: ABN/ STAT (1-2 weeks) _______ GENERAL GENETIC APPT ___________**

(If you believe your patients needs faster care, please call 404 785 6000 and ask for the Geneticist On Call)

*Referring Physician*

Name __________________________________ Practice Name_____________________________

Office Phone (___) ___________________________ Fax (___) ______________________________

* E-Mail address:____

*Primary Care Physician*

Name __________________________________ Practice Name_____________________________

Office Phone (___) ___________________________ Fax (___) ______________________________

E-Mail address:____

Insurance Information PLEASE ATTACH AN ENLARGED COPY OF INSURANCE CARD

Card Holder's Name ___________________________ DOB ____/_____/____ Gender_____________

Name of Insurance ____ Group ID # ___________________

Address to send claims: P. O. Box ___________________________ Member ID # _________________

City ____ State _____________________ Zip __________

*
Referring Diagnoses or Reported Symptoms:

___ Abnormal Lab Results ___ Abnormal Genetic Test ___ Abnormal growth ___ Café au lait spots ___ Coarse features ___ Congenital Anomalies ___ Developmental delay ___ Dysmorphic features ___ Failure to thrive ___% HT ___% WT ___ Frequent fractures ___ Hypotonic ___ Intellectual disability ___ Lethargy	___ Microcephalic ___ % HC ___ Macrocephalic ___ % HC ___ Autism Spectrum ___ r/o Marfan's ___ r/o Metabolic Disorder ___ r/o OI ___ Regression ___ Seizures ___ SN Hearing Loss (SNHL) ___ Vomiting/ diarrhea	___ Other: _________________________ _________________________ _________________________ _________________________ _________________________ _________________________

******PLEASE ATTACH SUPPORTING CLINICAL OBSERVATIONS, LABS AND NOTES WITH YOUR REFERRAL. YOU MUST INCLUDE OFFICIAL LAB REPORTS FOR ANY LABS MENTIONED IN THE REFERRAL ******

PLEASE COMPLETE AND FAX WITH PERTINENT MEDICAL RECORDS TO:
(404) 778-8562, ATTN: PEDIATRIC-ADULT CLINIC COORDINATOR

FOR OFFICE USE ONLY: Review Date:	Appt Date: Time:	Physician: