REFERRAL FOR GENETIC CONSULTATION WITH THE GREENWOOD GENETIC CENTER

Date of Referral: ______________________ Person making referral: ____

Referring Physician or Agency/Office: ____

Address: ___________________________________ Phone: ______________________ Fax: ______________________

Patient Name: ____ Male/Female
(First) (Middle) (Last)

Patient's DOB: ____________________ SS#: __________________________ Interpreter-Yes (Language__________)/No

Parent/Guardian: ____ Relationship: ______________________________

Address: _____________________________________ City: __________________State: ____________ Zip: ___________

Telephone Home: __________________________ Work: ________________________ Cell: _______________________

Primary:	**Secondary:**
Insurance Company: ______________________________	Insurance Company: ______________________________
Policy #: ____	Policy#: ____
Authorization #: __________________________________	Authorization #: ___________________________________

* Preauthorization number should be obtained before referring patients to the Greenwood Genetic Center

REASON FOR REFERRAL: ____

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SIGNATURE OF REFERRING PHYSICIAN

Greenwood Genetic Center only accepts referrals on patients residing in South Carolina. Consultation may include laboratory evaluation as recommended by the clinical geneticist. Please send/fax all pertinet medical records including laboratory results, radiology reports, newborn discharge summaries, eye exams, developmental records, IQ testing, etc along with this form. If pregnant-include date of delivery. We will return form when appointment scheduled with patient.

Greenwood Office	Columbia Office	Florence Office	Charleston Office	Greenville Office
Toll: 1-888-442-4363	Toll: 1-800-679-5390	Toll: 1-877-679-0927	Toll: 1-866-588-4363	Toll: 1-866-479-4363
Fax: 1-864-941-8114	Fax: 803-799-5391	Fax: 843-676-9881	Fax: 843-746-1002	Fax: 864-250-9582

Date of Appointment: _____________________________ Time: _____________________ Clinic: _________________________________

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