



GENETICS CENTER

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Genetics Referral

Please complete and fax this form to 714-288-3510

Patient Information

Does the patient live with someone other than the legal guardian? No Yes,
if yes, relationship_____

Patient Name:_____ Date of Birth:_____

Parent/Guardian:_____ Parent Phone:_____

Parent Cell:_____

Insurance:_____ ID#:_____ PPO EPO POS
 HMO Other_____

Please describe the patient's chief complaint and include onset and laboratory results:

What is the key question you want us to answer?

To expedite appointment scheduling, please provide the following:

- This completed form
- Medical records related to the chief complaint
- Pertinent laboratory results
- Patient demographics

Referring Provider:_____ Phone:_____ Fax:_____

Provider Address:_____ City:_____ Zip:_____

Physician's Signature:_____ Date:_____