Genetic Counseling Referral Form

Fax completed form to 1-800-893-0276 or email: support@tempus.com

NOTE: Please submit relevant medical records and insurance information.

Authorized Provider

Practice Name: _____ Account #: ZY947

Phone #: _____ Fax #: _____

Provider Name: _____ Provider Signature **(REQUIRED)**: _____

Patient Information

Patient Name: _____ Date of Birth: _____

☐ No specimen collected Date specimen sent to lab: _____

Accession No. (if applicable): _____ ICD10 **(REQUIRED)**: _____

Reason for Referral *(Please submit relevant medical records and insurance information.)*

☐ Tempus xG Hereditary Cancer Test – Powered by GeneDx

☐ Hereditary Cancer Familial Variant Testing

Please Indicate All Desired Services

☐ Pre-test and post-test genetic counseling: I authorize MyGeneTeam to request insurance authorization on my behalf. I authorize the MyGeneTeam genetic counselor to receive and provide test results to the patient.

☐ Pre-test genetic counseling only: I authorize MyGeneTeam to request insurance authorization on my behalf.

☐ Post-test genetic counseling only: I authorize the MyGeneTeam genetic counselor to receive and provide test results to the patient.

NOTE: MyGeneTeam will provide clinical and insurance information to the laboratory to facilitate testing and billing.