Genetic Counseling Referral Form

Fax OR Email completed form to: 1-800-893-0276 | support@tempus.com

NOTE: Please submit relevant medical records

Patient Information

Patient Name: _____ Date of Birth: _____

Date Specimen Sent to Lab: _____ Accession No. (if applicable): _____

☐ No specimen collected

Reason for Referral (Please submit relevant medical records)

☐ Tempus xG Hereditary Cancer Testing – Powered by GeneDx

☐ Hereditary Cancer Familial Variant Testing

Please Indicate All Desired Services

☐ Pre-test and post-test genetic counseling: I authorize the genetic counselor to provide pre-test genetic counseling and to receive and provide test results to the patient.

☐ Pre-test genetic counseling only: I authorize the genetic counselor to provide pre-test genetic counseling.

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

In my capacity as my patient's healthcare provider, I hereby authorize the genetic counselor to provide the patient's genetic counseling summary (including medical and family history information) to the performing laboratory, as this information is medically necessary for treatment, payment, diagnosis and testing purposes. I have discussed the disclosure of this information with my patient (or the patient's personal representative), who has authorized this disclosure of information for the above-referenced purposes. In addition to authorization for disclosure, the patient/patient's personal representative has further consented to being contacted via telephone, email or text (Data Rates May Apply) for purposes of scheduling a genetic counseling appointment. I have also informed the patient (or the patient's personal representative) of their right to revoke this consent. Genetic counseling may be performed by a licensed (where applicable by law), third party partner genetics professional not employed by the laboratory or its subsidiaries.

Authorized Provider

Practice Name: _____ Account #: ZY947

Phone #: _____ Fax # or Email for Genetic Counseling Summary: _____

Provider Name: _____ Provider Signature (REQUIRED): _____