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 _____

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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:

1365 Clifton Road NE, Building B, Suite 2200
Tel 404.778.8570 ▪ Fax 404.778.8562