Genetic Counseling & Testing Referral

Patient/Donor Information

Patient/Donor Name _____ DOB _____ /_____ /_____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Preferred Pronouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

Sex Assigned at Birth ☐ Female ☐ Male ☐ Intersex ☐ N/A

Partner Name (*if applicable) _____ DOB _____ /_____ /_____

Phone _____ Email _____

Preferred Pronouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

Sex Assigned at Birth ☐ Female ☐ Male ☐ Intersex ☐ N/A

Patient/donor must contact ORM Fertility at 503.274.9449 (Option 1) to schedule an appointment

Referral Information

☐ Self Referral

Referring Clinic/Physician/Agency _____

Referral Contact Name _____

Phone _____ Email _____

Please Indicate Service Requested

☐ Egg/Sperm Donor Candidate *(SHG - Donor)*

Donor ID Number _____

☐ Family History Consult & Written Summary ($350)

☐ Donor Carrier Screening ($199)

☐ Preconception Genetic Counseling ($250) *(SHG)*

For patients who have a possible or known genetic reproductive risk; patients planning to conceive using an egg or sperm donor; or those interested in being proactive about their family planning. Includes family history, genetic counseling, recommendations for genetic testing/follow-up, and presentation of proactive genetic screening options. Cost of carrier screening and other indicated genetic testing will be presented to patient.

Indication/history, if applicable: _____

_____

_____

☐ Genetic Carrier Screening (Cost of test + $100 brief consult fee) *(SHG-ECS)*

Sema4 283 gene Expanded Carrier Screen unless otherwise indicated. Does not include review of family history. Consult fee includes brief pre- and post-test check-in with patient. Carrier screening will be billed to insurance when possible; maximum cost of test to patient = $249/person; $349/couple.

Billing Information (Please Choose One)

☐ Patient is responsible payer

Billing Contact _____

☐ Please bill ordering clinic/agency

Phone/Email _____

Physician/Agency Coordinator Signature _____

Fax or email to which consult notes/results should be sent _____

Please send relevant medical records and genetic test results when indicated

Email this form to referrals@sharinghealthygenes.com or fax to 971-865-2103

Download the digital form at ormfertility.com/forms

Sharing Healthy Genes ORM FERTILITY

For Patients

We look forward to connecting with you!

You've been referred to ORM Fertility by your provider.

Please call 503.274.4994 (Option 1) to schedule your appointment.

Sharing Healthy Genes ORM FERTILITY