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 503.274.4946

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 (Opt. 1 + Opt. 3) to schedule your appointment.

Sharing Healthy Genes ORM FERTILITY