Cardiovascular Genetic Counseling Referral Form

Phone 513-865-5926 to reach a genetic counselor with any questions

FAX form to TriHealth Genetic Counseling at **513-852-1419**

(Referrals can also be made in Epic AMB REFERRAL TO CARDIOLOGY GENETICS [REF1218])

Patient Name: ____ DOB:______________________

Patient Phone Number: ______________________________________

Patient E-mail: ____

Patient referred for genetic risk assessment and coordination of genetic testing? **Yes** **No**

Ordering Physician: ____

Form Completed By: ____

Physician/Authorized Healthcare Provider signature required for referral:

Signature: ____ Date: ______________________

Reason for Referral (ADULT indications only):

- ☐ *Known mutation* in the following gene in the family: _______________
- ☐ Hypertrophic Cardiomyopathy (personal or family history)
- ☐ *Idiopathic* Dilated Cardiomyopathy (personal or family history)
- ☐ Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy (personal or family history)
- ☐ Familial Amyloidosis (Hereditary Transthyretin Amyloidosis) (personal or family history)
- ☐ Thoracic aortic aneurysm/dissection (personal or family history)
- ☐ Marfan syndrome (personal or family history)
- ☐ Loeys-Dietz syndrome (personal or family history)
- ☐ *Vascular* Ehlers-Danlos syndrome (personal or family history)
- ☐ Long QT syndrome (personal or family history)
- ☐ Brugada syndrome type 1 (personal or family history)
- ☐ Sudden cardiac arrest (personal or family history)
- ☐ Sudden cardiac death
- ☐ Familial Hypercholesterolemia (FH) or another dyslipidemia (personal or family history)
- ☐ Heritable heart defect (**ADULT**)

Other Personal or Family History: ____
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