UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

MILLER
SCHOOL OF MEDICINE
UNIVERSITY OF MIAMI

To:	**Human Genetics Department**	From:	
Address:	**1601 NW 12 Avenue #5049 (D-820) Miami, Florida 33136**	Pages:	**__, including cover sheet**
Hospital:	**University of Miami**	Date:	
Phone:	**305-243-6006**	Phone:	
Fax:	**305-243-3919**	Fax:	
Cc:		Contact:	**If you have problems with this transmission, please call:(305) 243-6006**

Delivery Instructions: ☒**Urgent**

Re: _____

Name: _____

DOB: _____

Thanks for the referral

Notice of disclosure: This information has been disclosed to you from records whose **confidentiality** is protected by Florida State Statues and Federal law. These laws prohibit you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by State/Federal law.

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In reliance on its contents, is strictly prohibited. If you have received this communication in error, please notify us immediately and destroy the documents. Thank you

Provider to Provider Release of Information for Treatment Purposes

CLINICAL GENETICS FAX REFERRAL FORM
University of Miami

1601 NW 12 Avenue #5049 (D-820)
Miami, Florida 33136
Phone: (305) 243-6006 - Fax: (305) 243-3919
www.medgen.med.miami.edu

Referral Date: _____

PATIENT INFORMATION

Patient name: _____

Address: _____

Date of birth: _____ Gender: ☐ Male ☐ Female

Name of parent or guardian: _____

Phone Number: _____ Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Insurance Information: _____

REFERRING PHYSICIAN INFORMATION

Physician name: _____

Address: _____

Phone Number: _____ Fax Number: _____

REASON FOR REFERRAL

Please indicate the reason for the referral:

☐ Diagnostic Evaluation due to:

- ☐ Multiple congenital anomalies: _____
- ☐ Neuromuscular disorder: _____
- ☐ Dysmorphic features: _____
- ☐ Developmental delay/autistic features: _____
- ☐ Other: _____

☐ Abnormal genetic test result: (Test result must be attached to this referral) _____

☐ Genetic counseling for known genetic condition: _____

☐ Family History of genetic condition: _____

☐ Cancer genetic counseling: _____

☐ Abnormal Newborn Screen/ Metabolic condition: _____

Other comments about this referral: _____

ATTACH ALL RELEVANT MEDICAL RECORDS INCLUDING IMAGING STUDIES, CONSULTATION LETTERS, GENETIC TEST RESULTS, PHOTOS, FOR THIS PATIENT AND/OR AFFECTED FAMILY MEMBERS

To make a referral, please:

- Provide your patient with our scheduling phone number to make an appointment: (305) 243-6006
- Once their appointment is made, fax this form to the University of Miami Genetics Clinic: (305) 243-3919
- Contact our genetic counselors if you have questions regarding the referral: UMGeneticsClinic@med.miami.edu

THANK YOU FOR YOUR REFERRAL TO THE UM GENETICS CLINIC

Please accept this document as a formal request for patient information for treatment purposes by the University of Miami physician listed. The release of this information from provider to provider for treatment is permitted by the Health Insurance Portability and Accountability Act (HIPAA) without patient authorization. *See 45 CFR Section 164.506(c).*