



**Aurora Health Care®** Milwaukee, Wisconsin

- Aurora St. Luke's Medical Center     West Allis Memorial Hospital, A.W.P.
- Aurora Sinai Medical Center         Other \_\_\_\_\_

**Aurora BayCare Medical Center**

**Aurora Health Care®**    **BAYCARE CLINIC**    Green Bay, Wisconsin

**GENETIC COUNSELING PROGRAM REFERRAL FORM \***

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_ (    ) \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Insurance (company and name of insured, phone): \_\_\_\_\_  
\_\_\_\_\_

Referring provider: \_\_\_\_\_

Provider's address: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_

Reason for referral: \_\_\_\_\_  
\_\_\_\_\_

Documents included:

- Patient Exam / Medical Records
- Copy (front and back) of Insurance Card
- Other: \_\_\_\_\_

Notes for Genetic Counselor: \_\_\_\_\_  
\_\_\_\_\_

Urgent Referral \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

Please fax this document and all other information to: (414) 385-2751; Attention: Angie Christensen.

Please call the Genetic Counseling office with urgent referrals or questions at (414) 649-5639 or (877) 647-2502.

**\*Please either fill out this document or write a script. Please also fax records if they are not in Cerner.**



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