# Step 1: Complete Genetic Counseling Referral Form

Individuals that meet criteria for the navigateAPDS testing program are eligible for **pre- and post-test** genetic counseling. This service is provided through Genome Medical, an independent genetic counseling service, and is made available by Pharming Healthcare, Inc. at no charge as part of the program. Patients will then be contacted by Genome Medical to schedule an appointment for counseling.

## Patient Information

Patient full name:

Patient representative:
*If applicable*

Relationship:
*If applicable*

Patient preferred phone:

Patient cell phone number:

Best time to call to schedule the appointment: am/pm Time Zone

Patient email address:

Referral for:

☐ Pre-test counseling ☐ Post-test counseling ☐ Both

Date of birth: / /

Primary language:
*If other than English*

Location at time of virtual appointment: State Zip

## Referring Provider Information

Site name:

Referring provider name: Phone: - -

Office contact: Phone: - -

Referring provider signature: WET SIGNATURE; NO STAMPS
*Required*

Date signed: / /

NPI:

Provider Fax: - -

Contact email:

Obtained patient consent: Yes ☐ No ☐

Fax genetic counseling summary report to Referring Provider: Yes ☐ No ☐

 

# Patient HIPAA Authorization & Consent

**Step 2:** Have patient sign the "Patient consent to receive genetic counseling" form.

**Step 3:** Fax the following to Genome Medical at 612-808-5186, or email to **supportgca@genomemedical.com**:

- Completed, signed provider referral form with signed patient consent form
- Reason for referral (include any relevant records)
- Genetic test results, if available

**Step 4:** Genome Medical will contact the patient to schedule a phone appointment, generally within 24–48 hours of receipt of the fax referral form. This service is provided at no cost to the clinic or to the patient.

**Step 5:** The patient will be called by telephone at the appointment time by a Genome Medical genetic counselor.

**Step 6:** A summary report of the consultation will be sent via fax to the referring physician, if requested above.

## Patient consent to receive genetic counseling

### Consent for genetic counseling

The purpose of this form is for you (the patient) to indicate your agreement to receive a genetic counseling appointment from Genome Medical. The services will be provided via telehealth (a phone consultation) between you and a genetic counselor. Your genetic counseling discussion will review genetic test results, medical conditions and additional genetic testing requested through your provider, if applicable. Telehealth is the delivery of health services from a distance, where the patient and the health services provider are not in each other's presence. This includes:

- Delivery of health care services by means of audio, video or other telecommunications or electronic technology.
- Transmission of patient-specific information, clinical information or documents by means of audio, video or other telecommunications or electronic technology.

Genome Medical adheres to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted to assure that individuals' health information is properly protected. This Privacy Rule allows for disclosure of protected health information (PHI) for treatment, payment and health care operations activities. This means we may disclose PHI to discuss your case with your referring provider or any health care professional that you or your referring doctor designate, including the genetic testing laboratory, to ensure continuity of care.

### These are the key points to which you agree:

- I have the right at any time to withhold or withdraw my consent to receiving health services via telehealth, without affecting my right to receive future health services from Genome Medical.
- The laws that protect the confidentiality of my health information (HIPAA) apply to telehealth. If my provider has referred me for this service, I agree that communication about my consultation may be shared with my provider.
- I understand that any additional testing and follow-up care is the responsibility of my provider.
- I understand that health information transmitted by means of audio, video or other telecommunications or electronic technology, despite security measures and encryption, could potentially be accessed by unauthorized persons.
- I have the right to inspect and obtain copies of my health records, including those related to health services provided to me by means of telehealth.
- I understand that my genetic counseling session may be monitored and recorded for record-keeping, training and quality assurance purposes.
- I understand that my signature below means that I agree to receive the services described above by means of telemedicine under the terms of this consent. I fully understand this consent and am signing it voluntarily.

**Patient full name:** (print)

**Patient signature:**

**Date signed:** / /

Patient representative (print):

Relationship to patient:

Patient representative signature:

Date signed: / /

 

*"if applicable" for patient representative – under age 18*