Cleveland Clinic

# PATIENT REFERRAL FOR GENETIC COUNSELING

Patient Name: _____ SS#: (optional) _____

CC#: _____ Date of Birth: _____ / _____ / _____

Telephone #: _____

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Reason for referral, ICD-9 code: _____

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_____ / _____
Printed Name of Referring Healthcare Provider *Telephone #*

_____ _____ / _____ / _____
Signature of Referring Healthcare Provider *Date*

**Please mail or fax this form along with pertinent records to:**

**Center for Personalized Genetic Healthcare**
**Cleveland Clinic**
**9500 Euclid Avenue, NE5**
**Cleveland, OH 44195**
**Phone: 216.636.1768**
**Fax: 216.445.6935**

**A patient service representative will contact the patient to schedule an appointment. The patient can also contact us at the telephone number listed above.**

*The CPT code for genetic counseling is 96040. The ICD9 or diagnosis code which is the reason for the referral is provided by the referring healthcare provider. Presently many insurance payors are recognizing genetic counseling as a covered service. It is the patient's responsibility to check with their payor to see if this is a covered service.*

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