Palmetto Health USC
MEDICAL GROUP

Department of Obstetrics and Gynecology
USC Genetic Counseling
Two Medical Park Road, Suite 103
Columbia, SC 29203

ADULT GENETIC COUNSELING REFERRAL

Date: _______________ Fax Form to: (803) 434-4596

PATIENT INFORMATION:

Name: ____ DOB: ______________________________

Address: ____ SSN: _______________________________

City/State/Zip: ____

Primary contact number: __________________________

Secondary contact number: ________________________

INSURANCE INFORMATION:

Private Insurance (type): _______________________________ Self Pay: _____________________________

Medicaid: Fee for Service **OR** HMO (please circle) Preauthorization #: ________________________

Name of Insured: ____________________________ Relationship to Insured: _______________________

PLEASE SEND COPIES OF PERTINENT MEDICAL RECORDS WITH REFERRAL.

REFERRING PHYSICIAN:

Referring Physician: ____

Practice name/Group:

____

Practice Address: ____

Office Contact: ___________________________ Phone: __________________ Fax: ____________________

INDICATION:

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____

PERTINENT FAMILY HISTORY:

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OTHER COMMENTS:

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Questions? Call (803) 545-5775