MyClinicalService

Physician Referral Form

Patient Information	
Patient Name **ALEXEI**	Patient Barcode Sticker
DOB, Medical Record Number (MRN)	

Requesting Provider	
Assigned Provider/Practice Name: Jane Ferreiro, MD / MyClinicalService	Specialty/Department: Pediatrics
Address: 900 23rd St NW Washington, DC 20037	Phone: (202) 555-1212 Facsimile #: (202) 555-1212

Consultant Provider	
Provider's Name: to be assigned	Specialty/Department: Molecular Science/M1 Training
Address: 2300 I St NW, Suite 201 Washington, DC 20052	Phone: (202) 555-1212 Facsimile #: (202) 555-1212

Referral Information	
Authorization No:	Authorization Type:

Reason for Referral: **Evaluation of Hemophilia**

Diagnosis: **D68.311 – Hemophilia**

Clinical Notes: 8 year old boy developed a severe hematoma on his left thigh after bumping into a boat's oarlock. His father indicated a long history of recurrent episodes of illness (bruises, bleeding episodes, and long painful recoveries) since shortly after birth.

The father's concern about his current condition is driven by the presence of a Monk with a questionable reputation who claims he alone and his mysticism can cure the boy. The father would like to take a more scientific approach and examine the possibility of an inherited bleeding disorder that appears to exist in many cousins of the maternal family.

Analyte tests have been ordered and a blood sample has been sent out for analysis with a Hemophilia genetic testing panel. The genetic test result report will be faxed to the Molecular Science/M1 Training program for evaluation.

Please consult with the father and send a copy of the final report back to this office. Thanks.

Procedures: Variant Interpretation – Molecular Impact Characterization

Visits Allowed: 3

Unit Type: V (VISIT)

Referral is Valid Until: 09/30/2018

Notes: Patient must arrive 30 minutes early, with a picture ID, Insurance card and have a copy of this referral. If the referred patient is a minor and anyone other than the child's parents are escorting the child to the appointment, a letter of consent by the parent is needed. Please bring a list of medications the patient is taking with you to this appointment (including over the counter).

Please send the final report by Fax to: (202) 555-1212

Signature:

Ferreiro, Jane, MD on 08/29/2018 at 11:43 AM EDT