Rare Genomes Project Referral Form

This form is for clinicians referring patients to the Rare Genomes Project. By completing this form, you attest to receiving permission from the patient to share their information with the study team. Completing this form does not guarantee acceptance to the study. Study staff will contact the patient by their preferred method and work with them to complete an application. All applications will be reviewed for eligibility.

Eligible patients must: 1) have a rare and genetically undiagnosed condition 2) live in the United States 3) speak English or Spanish 4) have access to a telephone and/or computer.

Please see https://raregenomes.org/eligibility-criteria for more information on eligibility criteria.

PATIENT INFORMATION

NAME: DATE OF BIRTH:

PREFERRED LANGUAGE: STATE OF RESIDENCE:

PARENT/GUARDIAN NAME: (IF APPLICABLE) RELATIONSHIP TO PATIENT:

CLINICAL INFORMATION

PLEASE USE ADDITIONAL SPACE ON NEXT PAGE TO PROVIDE MORE INFORMATION IF NEEDED

CLINICAL SYNOPSIS:

PRIOR GENETIC TESTING:

PATIENT/FAMILY CONTACT INFORMATION

PLEASE CHECK BOX FOR PREFERRED CONTACT METHOD

☐ PHONE: ☐ EMAIL:

REFERRING CLINICIAN INFORMATION

NAME: SPECIALTY:

AFFILIATION:

PHONE: EMAIL:

I have received permission from the Project study team to contact the patient/family. to share the above information and for the Rare Genomes

_____ _____

Signature Date

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ADDITIONAL INFORMATION

PLEASE USE AS NEEDED TO PROVIDE MORE INFORMATION