**MyClinicalService Physician Referral Form**

| **Patient Information** | | |
| --- | --- | --- |
| Patient Name  **Jorge** | | Patient Barcode Sticker |
| DOB, Medical Record Number (MRN)  ….………… …………………… …….. | |
| **Requesting Provider** | | |
| Assigned Provider/Practice Name:  Jane Ferreiro, MD / MyClinicalService | | Specialty/Department:  Internal Medicine |
| 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 Type II Diabetes** | | |
| Diagnosis: **E11.9 – Type II Diabetes** | | |
| Clinical Notes: 19 year old male complained of poor wound healing. He suspects he has a family history of diabetes because a grandparent had unexplained blindness and was a toe amputee. A lab test ordered by his PCP returned results suggesting high A1C levels.  A blood sample has been sent out for analysis with a hyperinsulinism panel. The genetic test result report will be faxed to the Molecular Science/M1 Training program for evaluation.  Please consult with the family 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: 09/30/2025 | | |
| 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 08/29/2024 at 2:41 PM EDT | | |