# Cancer Genetic Counseling Referral Form

Phone 513-865-5578 to reach a Genetic Counselor with any questions

**Fax** form to TriHealth Cancer Institute at **513-451-1356**

**(Referrals can also be made in EPIC by selecting "Ambulatory Referral to Genetic Oncology")**

Patient Name:_____DOB: _____

Patient Phone Number: _____

Patient referred for genetic risk assessment and coordination of genetic testing? **Yes** **No**

Appointment needed urgently to assist with medical decision making? **Yes** **No**
(all other appointments will be scheduled for next available)

Ordering Physician _____ Form Completed by _____

**Physician/Authorized Healthcare Provider signature required for referral**

Signature: _____ Date: _____

**Reason for Referral:** (please check all that apply)

- ☐ Known BRCA1 or BRCA2 mutation in patient or family
- ☐ Known mutation in another gene _____

**Hereditary Breast and Ovarian Cancer**
- ☐ Personal history of breast cancer
- ☐ Personal history of ovarian cancer
- ☐ Family history of breast and/or ovarian cancer

**Hereditary Colon and Endometrial Cancer**
- ☐ Personal history of colon cancer
- ☐ Personal history of endometrial cancer
- ☐ Family history of colon, endometrial, ovarian, stomach and/or other cancers
- ☐ Polyposis (greater than 10 cumulative colon polyps, any histology)
- ☐ Abnormal tumor studies, such as MSI or absent IHC.

Other Personal or Family History: _____
_____
_____