Intermountain Cancer Services
Healing for life

Cancer Genetic Counseling Referral

OFFICE USE:

Pt contacted: _____

Appt date/time: _____

Fax referral form and all pertinent records to 385-297-2305
For genetic counseling questions please call 435-251-5708

Preferred Location:

[ ] American Fork Hospital
[ ] Intermountain Medical Center
[ ] McKay-Dee Hospital
[ ] Dixie Regional Medical Center
[ ] Logan Reginal Hospital
[ ] Utah Valley Hospital

The cancer center staff will contact the patient directly to schedule an appointment.

Patient name: _____ DOB: _____

Patient telephone number: _____ e-mail: _____

Patient Insurance: _____ ID#: _____

_____ _____ _____

Referring provider | office phone | office fax

Indication:

[ ] patient affected

Type of cancer: _____ Age at diagnosis: _____

[ ] surgery pending Surgery Date: _____

[ ] family history [ ] known gene mutation in family (gene: _____)

Relative: _____ cancer/age @ Dx: _____
Relative: _____ cancer/age @ Dx: _____
Relative: _____ cancer/age @ Dx: _____
Relative: _____ cancer/age @ Dx: _____

[ ] genetic testing on hold in lab pending genetic counseling for insurance authorization

[ ] testing for at risk relative
name of family member previously tested by Intermountain Genetic Counseling: _____

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