



# 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:

- |   |  |
|---|--|
| <input type="checkbox"/> American Fork Hospital       | <input type="checkbox"/> Dixie Regional Medical Center |
| <input type="checkbox"/> Intermountain Medical Center | <input type="checkbox"/> Logan Regional Hospital       |
| <input type="checkbox"/> McKay-Dee Hospital           | <input type="checkbox"/> 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: \_\_\_\_\_

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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IHC CMP-880 / 2-03