Intermountain Cancer Services
Healing for life®

Cancer Genetic Counseling Referral

OFFICE USE:

Pt contacted: _____

Appt date/time: _____

Fax referral to:

Dixie Regional Medical Center:	**801-507-3998**
Intermountain Medical Center:	**801-507-3998**
Logan Regional Hospital:	**801-357-7786**
McKay-Dee Hospital:	**801-357-7786**
Utah Valley Hospital:	**801-357-7786**

- The cancer center staff will contact the patient directly to schedule an appointment.
- Please include any pertinent medical records (including copy of genetic test result for patient or family member) and copy of patient insurance card

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

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

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