

Clinical Cancer Genetic Counseling Referral Form

Patient Name: _____

Patient Date of Birth: _____

Patient Phone #: _____

Patient E-mail: _____

Patient UK MRN: _____

Patient Insurance: _____
(Attach copy of card)

Referring Provider: _____

Contact Number: _____
(Please provide direct #)

Phone: 859-323-2798
Fax: 859-257-0475
E-mail: CancerGenetics@uky.edu

*If this referral is not cancer-related,
please contact the Genetics &
Metabolism Clinic at 859-323-0396.*

Has the patient been diagnosed with cancer? Yes No Unknown

If yes, list the type(s) of cancer and age at diagnosis

First Cancer	Cancer Site/Type _____	Age _____
Second Cancer	Cancer Site/Type _____	Age _____
Third Cancer	Cancer Site/Type _____	Age _____

Does the patient have a family history of cancer or gastrointestinal polyps? Yes No

If yes, list how the person is related to the patient, the site of cancer or polyps, and age at diagnosis

Relationship	Maternal	Paternal	Cancer Site/Site, type, # of polyps	Age at Dx
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

If the patient or their family member has had testing, list their relationship to the patient and provide a copy of their test results if possible: _____

If the patient is being referred for an indication other than cancer, please describe the patient's clinical and family history below. ***If this is a referral for general genetics (not cancer-related), please contact their office at 859-323-0396.***
