HIGHLANDS
ONCOLOGY

New Patient Referral form for the CARE Clinic and Genetic Counseling

Phone: (479) 878-7065 Fax: (479) 313-7706 genetics@hogonc.com

Name: _____ ☐ Male ☐ Female DOB: _____

Phone #: _____ Email: _____

Referring provider: _____ Phone #: _____ Fax: _____

Contact at physician's office: _____ Direct Ext: _____

Service(s) Requested:

☐ **Pre-test genetic counseling** and **cancer risk assessment** for personal/family history of cancer

☐ Breast/Ovarian/Pancreatic/Prostate ☐ Colorectal/GI ☐ Other: _____

☐ Genetic testing **results discussion** for previous test results. **Gene mutation:** _____

☐ **Coordination of care** for known elevated cancer risk

☐ ADH/ALH ☐ LCIS ☐ Tyrer-Cuzick score:_____ ☐ Family history

☐ History thoracic RT <30 years of age ☐ Other: _____

Patient cancer history: _____ Age at diagnosis: _____ Pathology: _____

Family information:

☐ Genetic test results: _____ Relationship to pt:_____

Family history of cancer:

Maternal/Paternal	Relationship	Cancer Type	Age at Diagnosis

In order to process this referral quickly, please include the following documentation:

- ☐ **Demographics**
- ☐ **Insurance card**
- ☐ **Recent H&P and chart note**
- ☐ **Pertinent medical records (i.e. mammogram, pathology, scans, genetic test results)**