Henrico Doctors' Hospital
HCA
AN HCA AFFILIATE

Referral-Order Form
Cancer Genetics Clinic
Phone Number – (804) 237-7950; Virtual Fax (804) 477-1049

Patient Name: ____________________________	Referring Physician: ____________________
Patient Date of Birth: ______________________	Physician Phone Number: _______________
Patient's Phone Number(s): _________________	Physician Fax Number: _________________
_________________	
Patient's Insurance: _________________________	

Reason for consultation:

☐ Personal history of ___________________cancer, age of diagnosis______________________

☐ Patient request (please indicate reason) ____

☐ Strong family history of multiple types of cancer (please list)___________________________

☐ Strong family history of ____cancer(s)

☐ Family member with genetic mutation (please list specific gene)______________

Has the patient been notified that someone will contact them: **Yes No**
Are we permitted to leave a voice mail message? **Yes No**

If patient meets criteria for genetic testing, may I use you as the ordering physician for the lab test itself? **Yes No**

If patient tests positive for deleterious mutation, would you like for us to arrange for a medical oncologist to conduct a risk management consultation? **Yes No**

For Genetic Program Use Only: Date Fax Received: _______________

Thank you for your referral. We have received your faxed referral and the following has occurred:

☐ The patient has scheduled an appointment on: __________

☐ Repeated attempts to contact this patient to set up an appointment have been unsuccessful:
- Patient Contacted on: ___________________, _________________, _______________

☐ The patient declined to meet with a genetic educator (see reason below)
Comments: ____

Date Faxed to Referring MD:_________

 admin initials_____