The Breast Center
Charleston Area Medical Center

GENETIC COUNSELING REFERRAL FORM

FAX TO: The Breast Center ATTN: Genetics
Fax #: (304)388-2723 Questions: (304)388-2038

Date of referral: _____ Appointment Date: _____

PATIENT INFORMATION:

Patient name: _____DOB: _____

Address: _____

Primary phone #: _____Alternate phone#: _____

PHYSICIAN INFORMATION:

Referring physician: _____

Practice name: _____

Practice address: _____

Office phone #: _____ Office fax #:_____

INDICATION FOR REFERRAL

Personal History of:

- ☐ No history of cancer
- ☐ Breast cancer (Age____)
- ☐ Ovarian cancer (Age____)
- ☐ Colon cancer (Age____)
- ☐ Uterine cancer (Age ____)
- ☐ Other cancer:

_____

Family History of:

- ☐ No history of cancer
- ☐ Breast cancer (Age____)
- ☐ Ovarian cancer (Age____)
- ☐ Colon cancer (Age____)
- ☐ Uterine cancer (Age ____)
- ☐ Other cancer:

_____

Other information: _____

_____

This patient or a family member has had genetic testing: ☐ Yes ☐No

If yes, please indicate who, type of testing, result and include copy of test results with this referral if possible.

_____

Appointments are reserved for patients whose genetic test results may impact immediate medical decision-making, such as those awaiting surgical cancer treatments

☐ **URGENT** Surgery type/date (if known): _____

Comments: _____