Cincinnati Children's
Division of Human Genetics

Hereditary Cancer Risk Assessment Program
Fax Referral To: (513) 803-1111
Schedule by phone: (513) 636-4760 (option 1)

Today's Date: _____

Patient Name: _____**DOB:** _____

Home Phone: _____ **Work Phone:** _____

Referring Physician: _____ **Contact Person:** _____

Address: _____

Office Number: _____ **Fax Number:** _____

Requested Visit Location:
CCHMC **Clifton** ☐
CCHMC **West Chester/ Liberty** ☐
CCHMC **Fairfield** ☐

Please provide a genetic risk assessment for this patient related to:
- ☐ Breast cancer
- ☐ Ovarian cancer
- ☐ Colon cancer
- ☐ Uterine cancer
- ☐ Other cancer _____

Family/Personal history information:

_____

_____

This patient has previously had genetic testing ☐ YES ☐ NO
Results are: ☐ Positive ☐ Normal ☐ Pending

If you have any questions, please call:
Sara Knapke, MS, CGC (513) 803-0211
or
Erin Mundt, MS, CGC (513) 636-9626

For your information: This patient has been scheduled for a risk assessment

Appointment Date: _____

Appointment Time: _____

Patient Attended Appointment:
Yes (you will receive written consult note)
No (rescheduled)
Date: _____ **Time:** _____
Cancelled and not interested in rescheduling at this time
No-Show (please have patient call (513) 636-4760 to reschedule)