



Pediatric Hereditary Cancer Predisposition Program
Fax Referral To: (513) 803-1111

Today's Date: _____

Patient Name: _____ DOB: _____ MRN: _____

Home Phone: _____ Parents name(s): _____

Referring Physician: _____ Contact Person: _____

Physician Address: _____

Office Number: _____ Fax Number: _____

Reason for referral:

Family/Personal history information:

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

Please specify what testing (if any) has already been performed: _____

If you have any questions, please call:
Sara Knapke, MS, CGC (513) 803-0211
or
Erin Mundt, MS, CGC (513) 636-9626
To have counselor paged please call: (513) 636-4760

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)