Cincinnati Children's
changing the outcome together

Hereditary Cancer Risk Assessment Program Referral Form

Fax Referral To: (513) 803-1111

Name: _____
DOB: _____
MRN: _____

Schedule by phone: (513) 636-4760 (option 1) Hereditary Cancer Program Phone Line: 513-803-5131

Today's Date: _____

Patient Name: _____DOB: _____

Best Contact Number: _____

Referring Physician: _____ Contact Person: _____

Office Number: _____ Fax Number: _____

Requested Visit Location: ☐ Main Campus ☐ Mason Campus ☐ Telemedicine

This patient has a ***personal history*** of:

☐ Breast cancer
☐ Ovarian cancer
☐ Colon cancer
☐ Uterine cancer
☐ Other cancer _____

This patient has a ***family history*** of:
Please indicate who in the family was diagnosed (example: mother, father, sister, maternal aunt, paternal cousin)

☐ Breast cancer in _____
☐ Ovarian cancer in _____
☐ Colon cancer in _____
☐ Uterine cancer in _____
☐ Other cancer _____

This patient previously had genetic testing: ☐ Yes ☐ No

Type of test: Results are: ☐ Positive ☐ Normal ☐ Pending

☐ **Urgent Referral: Please provide a brief explanation of why patient needs to be seen urgently (include dates of surgery if relevant and available). We may contact you to discuss the referral.**

_____

_____

Urgent only: For *urgent referrals* please call the Hereditary Cancer Program at 513-803-5131.
We reserve weekly slots at Main Campus to accommodate urgent patients.

_____

Signature/Credentials Printed Name Date