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: _____

Best Contact Number: _____

Referring Physician: _____ Contact Person: _____

Office Number: _____ Fax Number: _____

Requested Visit Location: CCHMC Clifton ☐
CCHMC Mason ☐

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 (ie: 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.

_____

_____

Please fax urgent referrals to 513-803-4844 AND call the Hereditary Cancer Program at 513-803-0750.
We reserve weekly slots at CCHMC Clifton in order to accommodate urgent patients.