Patient Name:

DOB:

MR #:

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

ONCOLOGY GENETICS REFERRAL

Index to Consult/Referral/Transfer
Date: ______________________________

REFERRING PROVIDER INFORMATION:

______________________	______________________	______________________
Provider Name/Credentials	Provider NPI#	Clinic/Organization Telephone Number
Clinic/Organization Name & Address	City, State & Zip Code	
Clinic/Organization Fax Number		

PATIENT INFORMATION:

______________________ Gender: ☐ Male ☐ Female ☐ X ☐ Nonbinary ______________
Patient Name Patient DOB

______________________	______________________
Patient Address	City, State & Zip Code
Patient Telephone Number	Patient Email Address

Oncology History:

Does the patient have a new diagnosis of cancer? (check one) ☐ **Yes** ☐ **No**
If yes, what type of cancer?______________________________

Does the patient have a personal history of cancer? (check one) ☐ **Yes** ☐ **No**
If yes, what type of cancer and at what age?______________________________

Does the patient have a family history of cancer? (check one) ☐ **Yes** ☐ **No**
If yes, what type of cancer and at what age?______________________________

Genetic Counseling/Testing Order (select one based on patient medical history)

☐ **Oncology Genetic Counseling – Urgent**
- Patient has a new diagnosis of cancer and the results of genetic testing may impact treatment planning in the immediate future.

☐ **Oncology Genetic Counseling – Intermediate**
- Patient has a new diagnosis of cancer, genetic testing results may impact treatment planning however results are not needed for several weeks (usually due to neoadjuvant chemotherapy or other delays to planned treatment)

☐ **Oncology Genetic Counseling – Routine**
- Patient does not have a personal history of cancer; referral is based on family history
- Patient has a personal history of cancer however no treatment decisions are pending based on genetic testing

If following genetic counseling the patient wishes to proceed with genetic testing, I authorize UW Health Oncology Genetic Counselors to determine the appropriate test and facilitate sample collection and submission to the appropriate testing company as indicated by patient need and insurance requirements.

Signature: ______________________________ Date: _____/_____/_____Time: __________ Pager#: __________

Please fill out completely and fax to the UW Health Oncology Genetics office at (608) 662-4448