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