Revised 12.2023

Markey Cancer Center
An NCI Comprehensive Cancer Center

Clinical Cancer Genetic Counseling Referral Form

Patient Name: _____

Patient Date of Birth: _____
Patient Phone #: _____
Patient E-mail: _____
Patient UK MRN: _____
Patient Insurance: _____
(Attach copy of card)
Referring Provider: _____
Contact Number: _____
(Please provide direct #)

Phone: 859-323-2798
Fax: 859-257-0475
E-mail: CancerGenetics@uky.edu

If this referral is not cancer-related, please contact the Genetics & Metabolism Clinic at 859-323-0396.

Has the patient been diagnosed with cancer? ☐Yes ☐No ☐Unknown

If yes, list the type(s) of cancer and age at diagnosis

First Cancer Cancer Site/Type_____ Age_____

Second Cancer Cancer Site/Type _____ Age_____

Third Cancer Cancer Site/Type _____ Age_____

Does the patient have a family history of cancer or gastrointestinal polyps? ☐Yes ☐No

If yes, list how the person is related to the patient, the site of cancer or polyps, and age at diagnosis

Relationship	Maternal	Paternal	Cancer Site/Site, type, # of polyps	Age at Dx
	☐U	☐U		
	☐U	☐U		
	☐U	☐U		
	☐U	☐U		
	☐U	☐U		

If the patient or their family member has had testing, list their relationship to the patient and provide a copy of their test results if possible:_____
_____

If the patient is being referred for an indication other than cancer, please describe the patient's clinical and family history below. ***If this is a referral for general genetics (not cancer-related), please contact their office at 859-323-0396.***

_____
_____
_____
_____

****PLEASE ATTACH A DEMOGRAPHIC SHEET, A COPY OF RECENT CLINIC NOTE AND (IF APPLICABLE) PATHOLOGY REPORT****