



Clinical 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: _____

Referral to:
Justine M. Cooper, MS, CGC
Certified Genetic Counselor

Terra Lucas, MS, CGC
Certified Genetic Counselor

Phone: 859-323-2222
Fax: 859-323-9548

Appointment Date: _____
Appointment Time: _____

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 _____ Age _____

Second Cancer Cancer Site _____ Age _____

Third Cancer Cancer Site _____ 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
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Is the patient a member of an at risk population? (i.e. Ashkenazi Jewish) Yes No Unknown

Has the patient or any family members already had genetic testing? Yes No Unknown

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

If a mutation has been identified in the patient please fax these results to us. If a family member has had a mutation found and we do not have a copy of the results, we will not test the patient.

****IF THE PATIENT IS NOT A UK PATIENT, PLEASE ATTACH A DEMOGRAPHIC SHEET, A COPY OF RECENT CLINIC NOTE AND PATHOLOGY REPORT, IF APPLICABLE****

If the patient is being referred for an indication other than cancer, please describe the patient's clinical and family history below:

