CANCER GENETICS PROGRAM
Genetic Cancer Risk Assessment Referral Form

HAWAI'I PACIFIC HEALTH
KAPI'OLANI
PALI MOMI
STRAUB
WILCOX
CREATING A HEALTHIER HAWAI'I

Fax To: Sandra Dreike, MS, CGC Genetic Counselor
Fax Number: (808) 973-3401
Scheduling: Health Connection (535-7000, press 3)

From: _____
Fax Number: _____
Phone Number: _____

Name of Patient: _____ Date of Birth ____/____/____ MRN_____

Address:_____

Telephone Home: (____) _____ Work: (_____) _____

INDICATIONS FOR REFERRAL TO CANCER GENETICS PROGRAM ***(this includes an evaluation by a genetic counselor and may include an evaluation by a clinical geneticist)*:**

☐ Breast/Ovarian Cancer Risk Assessment (BRCA1, BRCA2)
☐ Colorectal/Endometrial Cancer Risk Assessment (HNPCC, FAP, Juvenile Polyposis)
☐ Other Genetic Cancer Syndrome _____

PATIENT CANCERNS ***(check all that apply)*:**

☐ Concern due to patient's personal history of cancer
☐ Concern due to patient's family history of cancer
☐ Patient seeking information to make best possible medical treatment decisions
☐ Concern about cancer risk for unaffected relatives
☐ Other_____

DOCUMENTATION:

☐ Patient's pathology/oncology reports accompany this referral
☐ Patient's pertinent test results accompany this referral
☐ Patient's family history information/documentation accompanies this referral

****File this form in the patient's chart after faxing as documentation of referral****

This patient has an appointment for genetic cancer risk assessment with the HPH Cancer Genetics Program on:

(Date)_____ at (time) _____ at____ Hawai'i Community Genetics
____ Straub, Pearlridge

to discuss her/his personal and/or family history of cancer to discuss genetic risk assessment, genetic testing and high risk cancer management options.

Referring Physician: (signature) _____ Date:_____