



HAWAI'I PACIFIC HEALTH

Kapi'olani • Pali Momi • Straub • Wilcox

**Hawai'i Pacific Health
Cancer Genetics Program**

Genetic Cancer Risk Assessment Referral Form

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

Name of Patient _____ Date of Birth ___/___/___ MRN _____
Address _____
Telephone Home: (____) _____ Work: (____) _____

Indications for Referral to the 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, Lynch, FAP, Juvenile Polyposis)
 Other Genetic Cancer Syndrome _____

Patient Concerns (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 this referral

This patient has an appointment for a 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: _____