CANCER GENETICS PROGRAM
Genetic Cancer Risk Assessment Referral Form

HAWAIʻI PACIFIC HEALTH
KAPIʻOLANI
PALI MOMI
STRAUB BENIOFF
WILCOX
CREATING A HEALTHIER HAWAIʻI

Fax To: Hawaii Community Genetics
Fax Number: 808-373-7599
Scheduling: Health Connection 808-373-7555

Requesting MD/Contact Person: _____
Fax Number: _____
Phone Number: _____

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

Address:_____

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

PCP _____ Tel:_____ Fax: _____

Insurance _____ Subscriber #_____ Policy Holder Name & DOB _____

Medical Benefit Code (i.e. 800 or X-B) _____

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

- ☐ Personal history of breast cancer (C50.919/Z85.3)
- ☐ Personal history of ovarian cancer (C56.9/Z85.43)
- ☐ Personal history of colon cancer (C18.9)
- ☐ Personal history of GI polyps (K63.5)
- ☐ Personal history of other cancer (Details:_____)
- ☐ Personal history of known gene mutations (Details: _____)
- ☐ No personal history of cancer
- ☐ Family history of breast cancer (Z80.3)
- ☐ Family history of ovarian cancer (Z80.41)
- ☐ Family history of uterine cancer (Z80.49)
- ☐ Family history of colon/GI cancer (Z80.0)
- ☐ Family history of GI polyps (Z83.71)
- ☐ Family history of known gene mutation (Relationship and other details:_____)

Available Family History

Relationship	Cancer Site	Age Diagnosed

Documentation: Please fax relevant medical records and labs with form **unless part of HPH EPIC** system (i.e. pathology/oncology reports, test results) in order to obtain authorization for the office visit.

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

Referring Physician: (signature) _____ Date:_____