GENETICS CENTER

211 South Main Street, Orange, California 92868
Tel 714.288.3500 & 888.4.GENETIC Fax 714.288.3510
www.geneticscenter.com

Cancer Genetics Referral for Genetic Counseling

Please complete and fax this form to 714-288-3510

Patient Information

Name:_____ Date of Birth:_____

Address:_____

Home Phone:_____ Work/Cell Phone:_____

Insurance:_____ ID#:_____ □ PPO □ EPO □ POS
(for authorization requests, please request cpt code 99245) □ HMO □ Other_____

Medical Information/Indication

□ Personal History of Cancer: Diagnosis:_____

□ Family History of Cancer: Family Member:_____ Dx:_____

Family Member:_____ Dx:_____

□ Other Information:_____

Please Attach (if available)

□ Facesheet □ Insurance Card □ Pathology report(s)

Referral Information

Referring Physician:_____ Phone:_____

Based on this patient's personal and/or family history of cancer, I am referring him/her for the genetic services checked above as medically necessary care.

Physician's Signature:_____ Date:_____

If needed,may we contact the patient directly: □ Yes □ No