REFERRAL TO CANCER GENETICS CLINIC

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Please complete and fax this form to 205.975.6389. If available, include recent clinic note, pathology report, and UAB Patient Medical/Family History Questionnaire.

Referring Provider ____
Clinic Contact ____
Provider Site Address____
Referring Provider Phone ______________________ **Fax** ______________________________

Patient Name _______________________________ **Patient DOB** _____________________
Patient Phone Number ____
Patient Address ____

Indications for Referral (please check all that apply)

- ☐ **Early-onset cancer** (<50 yo)
- ☐ **Bilateral or multiple primary cancers**
- ☐ **Clustering of cancer or polyposis in close relatives**
  Ex: breast/ovarian, colon/uterine, breast/uterine/thyroid/renal, melanoma/pancreatic
- ☐ **Rare cancer/presentation of cancer**
  Ex: male breast cancer, adrenocortical carcinoma, medullary thyroid cancer
- ☐ **Multiple dermatologic manifestations with personal and/or family history of cancer**
  Ex: Lipomas, fibromas, neurofibromas, dysplastic nevi, BCC, melanoma
- ☐ **Known familial mutation** in a cancer susceptibility gene
  Ex: BRCA 1/BRCA 2, MMR gene mutation

The maternal and paternal sides of the family should be considered independently for familial patterns of cancer