Genetic Counseling/Testing Order

Piedmont ONCOLOGY

Cancer Genetics Program **Phone: 404.425.7300**	Genetic counseling appointments are available via telehealth. In-person appointments are available at some locations.

Please fax completed form to central scheduling at 855.218.6369

- Attach recent clinic note with referral form (unless already in Epic)
- Patient will be contacted to schedule genetic counseling appointment. Please have patient call Piedmont Genetics at 404.425.7300 if he/she has not received a call within one week.
- **Note:** For **urgent appointments**, send in referral form AND have patient or office call Genetics department directly at 404.425.7300, prompt 2.

Patient name: _____

Date of birth: _____ /_____ /_____ Sex: _____ Gender: _____

ICD Code (REQUIRED): _____ Insurance co.: _____

Phone: _____ Phone 2/email: _____

Address: _____

Language services needed?: ☐ No ☐ Yes _____

Referring MD: _____ Practice: _____

Office phone: _____ Office fax: _____

Indications for referral - check all that apply

☐ **No personal history of cancer**

Personal Diagnosis/History of Cancer:

- ☐ Breast cancer — female (C50.919)
- ☐ Breast cancer — male (C50.929)
- ☐ Colon cancer (C18.9)
- ☐ Rectal cancer (C20)
- ☐ Pancreatic cancer (C25.9)
- ☐ Stomach cancer (C16.9)
- ☐ Prostate cancer (C61)
- ☐ Ovarian cancer (C56.9)
- ☐ Uterine cancer (C55)
- ☐ Kidney cancer (C64.9)
- ☐ Thyroid cancer (C73)
- ☐ Colon polyps (Z86.010)
- ☐ Other _____

Family History of Cancer:

- ☐ Breast cancer (Z80.3)
- ☐ Colorectal cancer (Z80.0)
- ☐ Stomach cancer (Z80.0)
- ☐ Pancreatic cancer (Z80.0)
- ☐ Ovarian cancer (Z80.41)
- ☐ Uterine cancer (Z80.49)
- ☐ Prostate cancer (Z80.42)
- ☐ Kidney cancer (Z80.51)
- ☐ Thyroid cancer (Z80.8)
- ☐ Leukemia (Z80.6)
- ☐ Lymphoma (Z80.7)
- ☐ Other _____

Prior Genetic testing:

Is patient being referred for post-test counseling (discussion of completed testing)?

☐ No ☐ Yes If Yes, include a copy of test results (unless already available in Piedmont Epic).

Has a family member had a prior positive genetic test for inherited cancer risk?

☐ No ☐ Yes If Yes, provide copy of relative's test report and/or name of gene: _____

Physician signature: _____ **Date:** _____

I certify the need for these services furnished under this plan of treatment while under my care. **Note:** The referring physician will be the ordering physician on any genetic testing ordered relating to the genetic counseling consultation.