Cancer Genetic Counseling Referral

Palmetto Health USC
OBSTETRICS AND GYNECOLOGY
GENETIC COUNSELING

Date _____

Fax referral to **803-434-4596**
For questions call **803-545-5775**

Patient Information

Name_____

Date of birth_____ Social Security Number_____

Address_____

City/State/ZIP_____

Primary contact number_____ Secondary contact number_____

Insurance Information *(send copies of pertinent medical records, including pathology report, surgical and/or oncology note)*

Private Insurance (type) _____ Self-pay _____

Medicaid: ☐ Fee for service ☐ HMO Preauthorization # _____

Name of insured _____ Relationship to insured _____

Referring Physician

Referring physician_____

Practice name/group_____

Practice address_____

Office contact_____

Phone_____ Fax_____

Indication *(check all that apply)*

Personal History

☐ Breast Cancer (age_____)
☐ Ovarian Cancer (age_____)
☐ Colon Cancer (age_____)
☐ Prostate Cancer (age_____)
☐ Other _____

Family History

☐ Breast Cancer (relationship_____)
☐ Ovarian Cancer (relationship_____)
☐ Colon Cancer (relationship_____)
☐ Prostate Cancer (relationship_____)
☐ Other _____ (relationship_____)

Was the patient recently diagnosed? ☐ Yes ☐ No

Has a patient's relative tested positive for a mutation in a cancer gene? ☐ Yes ☐ No
If yes, please send a copy of the relative's report or request the patient bring a copy of the report to their appointment.

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Suite 103
Columbia, SC 29203
803-545-5775 phone
803-434-4596 fax

PHUSCMG.org