Revised 7.2021

HealthCare
MARKEY CANCER CENTER

Clinical Cancer Genetic Counseling Referral Form

Patient Name: _____

Patient Date of Birth: _____

Patient Phone #: _____

Patient E-mail: _____

Patient UK MRN: _____

Patient Insurance: _____
(Attach copy of card)

Referring Provider: _____

Contact Number: _____
(Please provide direct #)

Phone: 859-323-3083
Fax: 859-257-0475
E-mail: CancerGenetics@uky.edu

Michael Gosky, MS, LGC
Licensed Genetic Counselor

Terra Lucas, MS, LGC
Licensed Genetic Counselor

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Licensed Genetic Counselor

Has the patient been diagnosed with cancer? ☐Yes ☐No ☐Unknown

If yes, list the type(s) of cancer and age at diagnosis

First Cancer Cancer Site/Type_____ Age_____

Second Cancer Cancer Site/Type _____ Age_____

Third Cancer Cancer Site/Type _____ Age_____

Does the patient have a family history of cancer or gastrointestinal polyps? ☐Yes ☐No

If yes, list how the person is related to the patient, the site of cancer or polyps, and age at diagnosis

Relationship	Maternal	Paternal	Cancer Site/Site, type, # of polyps	Age at Dx
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

Is the patient a member of an at risk population? (i.e. Ashkenazi Jewish) ☐ Yes ☐No ☐Unknown

Has the patient or any family members already had genetic testing? ☐Yes ☐No ☐Unknown

If family member has had testing, list their relationship to the patient and provide a copy of their test results if possible-

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If a mutation has been identified in the patient please fax these results to us. If a family member has had a mutation found and we do not have a copy of the results, we will not test the patient.

****IF THE PATIENT IS NOT A UK PATIENT, PLEASE ATTACH A DEMOGRAPHIC SHEET, A COPY OF RECENT CLINIC NOTE AND PATHOLOGY REPORT, IF APPLICABLE****

If the patient is being referred for an indication other than cancer, please describe the patient's clinical and family history below. *If this is a referral for general genetics, please contact their office at 859-323-0396.*

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