Palmetto Health USC MEDICAL GROUP

Department of Obstetrics and Gynecology
USC Genetic Counseling
Two Medical Park Road, Suite 103
Columbia, SC 29203

CANCER GENETIC COUNSELING REFERRAL

Date: _____ Fax Form to: (803) 434-4596

PATIENT INFORMATION:

Name: _____ DOB: _____

Address: _____ SSN: _____

City/State/Zip: _____

Primary contact number: _____

Secondary contact number: _____

INSURANCE INFORMATION:

Private Insurance (type): _____ Self Pay: _____

Medicaid: Fee for Service **OR** HMO (please circle) Preauthorization #: _____

Name of Insured: _____ Relationship to Insured: _____

PLEASE SEND COPIES OF PERTINENT MEDICAL RECORDS INCLUDING PATHOLOGY REPORT, SURGICAL AND/OR ONCOLOGY NOTE.

REFERRING PHYSICIAN:

Referring Physician: _____

Practice name/Group: _____

Practice Address: _____

Office Contact: _____ Phone: _____ Fax: _____

INDICATION: (PLEASE CHECK ALL THAT APPLY)

Personal History	**Family History**
___ Breast Cancer (Age ___)	___ Breast Cancer (Relationship _____)
___ Ovarian Cancer (Age ___)	___Ovarian Cancer (Relationship _____)
___ Colon Cancer (Age ___)	___ Colon Cancer (Relationship _____)
___ Prostate Cancer (Age ___)	___ Prostate Cancer (Relationship _____)
___ Other _____	___ Other _____ (Relationship _____)

--Is the Patient recently diagnosed? Yes **OR** No (please circle)

--Has a patient's relative tested POSITIVE for a mutation in a cancer gene? Yes **OR** No
If so, please send a copy of the relative's report or request the patient bring a copy of the report to their appointment.

Questions? Call (803) 545-5775