

EPIC Referral for Cancer Genetic Counseling:

1. Click: **Amb Referral for CIOS**
2. Select: **Genetics** within order
3. Select: Faris Rd. or Spartanburg for location



Cancer Genetic Counseling Referral Form

Center for Integrated Oncology and Survivorship

1. Select Appointment Location

Greenville

900 W. Faris Rd. Floor 1
 Greenville, SC 29605
 Appointments: **864-455-1346**
 Fax: **864-672-7802**

Spartanburg

120 Dillon Drive
 Spartanburg, SC 29307
 Appointments: **864-699-5700**
 Fax: **864-672-7802**

*If you would like to speak to a genetic counselor, please call **864-455-5836** (Greenville) or **864-699-5700** (Spartanburg).*

2. Enter Referral Source

Date of Referral: _____ Referring Provider: _____ Office Contact: _____

Provider's Phone Number: _____ Provider's Fax Number: _____

Date/Time of genetic counseling appointment if already scheduled: _____

3. Enter Patient Information

Patient Name: _____ SSN/MRN _____ DOB: _____

You do not need to complete this section if you attach the patient's demographic sheet and insurance information to this form.

Patient address: _____ Telephone (home): _____
 _____ (work/cell): _____

Primary Insurance: _____ Policy #: _____

Authorization #: _____

4. Select Reason for Referral (check all diagnosis codes that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> C50.____ Breast cancer | <input type="checkbox"/> C25.9 Pancreatic cancer | <input type="checkbox"/> Z80.3 Family hx breast cancer |
| <input type="checkbox"/> C56.9/C57 Ovarian/fallopian cancer | <input type="checkbox"/> C43.9 Melanoma | <input type="checkbox"/> Z80.41 Family hx ovarian cancer |
| <input type="checkbox"/> C55 Endometrial cancer | <input type="checkbox"/> Z85.____ Past hx ____ cancer | <input type="checkbox"/> Z80.0 Family hx of GI cancer |
| <input type="checkbox"/> C18.9/C20 Colon/rectal cancer | <input type="checkbox"/> Z14.8 Patient is known mutation carrier | <input type="checkbox"/> Z15.0__ Known hereditary cancer syndrome in family (no mutation) |
| <input type="checkbox"/> K63.5 Colon polyps | <input type="checkbox"/> Z84.81 Known gene mutation in family | |

Other: _____

5. Provide Physician Authorization for Genetic Counseling and Testing

Physician Signature: _____ Physician's Name (printed): _____

**PLEASE FAX THIS ORDER, COPY OF INSURANCE CARD AND RELEVANT MEDICAL RECORDS TO
 864-672-7802**