GREENVILLE HEALTH SYSTEM
Cancer Institute

Center for Integrative Oncology & Survivorship

Cancer Genetic Counseling Referral and Test Order Form

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)

☐	C50.__	Breast cancer	☐	C25.9	Pancreatic cancer	☐	Z80.3	Family hx breast cancer
☐	C56.9/C57	Ovarian/fallopian cancer	☐	C43.9	Melanoma	☐	Z80.41	Family hx ovarian cancer
☐	C55	Endometrial cancer	☐	Z85.__	Past hx ___ cancer	☐	Z80.0	Family hx of GI cancer
☐	C18.9/C20	Colon/rectal cancer	☐	Z14.8	Patient is known mutation carrier	☐	Z15.0__	Known hereditary cancer syndrome in family (no mutation)
☐	K63.5	Colon polyps	☐	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