

# Cancer Genetics Risk Assessment Program Referral and Laboratory Order Form

St. Vincent Hospital  
8301 Harcourt Rd. #100  
Indianapolis, IN 46260

Appointments: 317-338-RISK (7475) FAX: 317-583-2GEN (2436)

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

- Please contact this patient
- Patient has appointment \_\_\_\_\_
- STAT:** (Patient has treatment decisions that will be urgently affected by the outcome of genetic test results.)

## We are referring the above patient for (check all that apply):

- Genetic counseling and risk assessment
- Genetic testing for:
  - BRCA1/2 sequencing
  - Multisite 3 BRAC Analysis
    - Reflex to full sequencing
  - Single Site BRCA \_\_\_\_\_
  - MLH1/MSH2/MSH6 sequencing
- Clinical breast exam and SBE education with Nurse Practitioner
- Single Site MLH1/MSH2/MSH6 \_\_\_\_\_
- MSI and IHC on colon tumor
- APC/MYH sequencing
- Single Site APC \_\_\_\_\_
- Other \_\_\_\_\_

## Reason for Referral/Testing (please check all that apply and indicate ICD9 code)

- |   |   |
|---|---|
| <input type="checkbox"/> Breast cancer 174.____                       | <input type="checkbox"/> Ovarian cancer 183.0                           |
| <input type="checkbox"/> Fibrocystic breasts 610.1                    | <input type="checkbox"/> Uterine cancer 182.____                        |
| <input type="checkbox"/> DCIS 233.0                                   | <input type="checkbox"/> Personal past history ovarian cancer v10.43    |
| <input type="checkbox"/> Personal past history breast cancer v10.3    | <input type="checkbox"/> Family history of ovarian cancer v16.41        |
| <input type="checkbox"/> Family history breast cancer v16.3           | <input type="checkbox"/> Family history of known mutation carrier v18.9 |
| <input type="checkbox"/> Colon cancer 153.____                        | <input type="checkbox"/> Other _____                                    |
| <input type="checkbox"/> FAP 211.3                                    | <input type="checkbox"/> Other _____                                    |
| <input type="checkbox"/> Personal past history colon cancer v10.0____ |   |
| <input type="checkbox"/> Family history of colon cancer v16.0         |   |

Referring Physician \_\_\_\_\_

Phone Number: \_\_\_\_\_

Contact: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

MD Signature \_\_\_\_\_

Please fax, along with records, patient demographics and a copy of the patient's insurance card to: (317) 583-2436, or call (317) 338-RISK to schedule an appointment.