



HEREDITARY CANCER RISK COUNSELING REFERRAL FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Health Plan: _____

Phone Number(s): _____ Primary Language: _____

Please contact patient directly to schedule initial consultation, or

Patient will contact your office to schedule initial consultation: (805) 898-2204

[If patient has an HMO, please request authorization for 96040x4]

REFERRAL INFORMATION

Referring Provider: _____ Fax: _____

REASON FOR REFERRAL

Personal history of cancer → Diagnosis: _____ Age at diagnosis: _____

Family history of cancer → Family member: _____ Diagnosis: _____

Family member: _____ Diagnosis: _____

Family member: _____ Diagnosis: _____

Other → Indication: _____

PLEASE ATTACH TO REFERRAL, IF AVAILABLE:

Facesheet Copy of insurance card(s) Pathology reports/medical records

As you may know, both state and federal legislation provide protection against genetic discrimination and there are no documented cases of genetic discrimination based on genetic testing for cancer predisposition.

I am referring this patient for hereditary cancer risk assessment as medically necessary care

Provider Signature

Date

For CCSB Office Use Only

Patient has been scheduled for: _____

Notes:

**PLEASE FAX THIS REFERRAL FORM TO: (805) 569-7710
OR EMAIL TO: GENETICS @CCSB.ORG**