METHODIST HEALTH SYSTEM

Methodist Health System Hereditary Cancer Risk Program

***All Genetic Counseling Visits will be conducted by GeneMatters via Telehealth.**

Referrals CANNOT be completed unless the attached Release of Information form is completed as well.

Step 1: Patient Complete Release of Information

Step 2: Clinic Staff to Complete Referral Form

Patient Information

Patient Name:	Date of Birth:	Primary Language:
Location at time of appointment: State: _____ Zip: _____	Patient Preferred Phone Number: _____-_____-_____ Patient Preferred Email: _____	

Patient Cancer History

Cancer Diagnosis: _____ Yes _____ No Cancer Type: _____	Age at Diagnosis: _____ Current Age: _____
Reason for Referral:	

Please mark if applicable:

_____ **Medical treatment/decisions are pending the results of genetic testing**

Referring Provider Information

Referring Provider Name:	Phone:
Clinic Name:	Fax:

Additional Comments:

_____

_____

_____

_____

Step 3: Email Completed form to mecc.genetics@nmhs.org. Please attach applicable clinic notes/pathology reports.

Hospital Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

NOT PERMANENT PART OF MEDICAL RECORD