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:	MRN#:
Insurance Information:	Patient Preferred Phone Number: ______-_________-__________ Patient Preferred Email: ____	

Patient Cancer History

Cancer Diagnosis: _____ Yes _____ No Cancer Type: _____________________________	ICD-10 Code:
Reason for Referral:	

Please mark if applicable:

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

________ **Pathology Report**

Referring Provider Information

Referring Provider Name:	Phone:
Clinic Name:	Fax:

Additional Comments:

____

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____

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

Phone: 402-354-5276 Fax: 402-354-2520

Patient Label

NAME:____________________________DOB:_____________

FIN:___________________________MRN:_________________

NOT PERMANENT PART OF MEDICAL RECORD

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