



Methodist Health System – Hereditary Cancer Risk Program

Phone: 402-354-5276

Fax: 402-354-2520

E-mail: mecc.genetics@nmhs.org

Important Information

- Genetic counseling is done via telehealth by a trusted third-party partner
- A signed Release of Information (ROI) form is required to process referrals
- We only accept referrals for patients with a personal or family history of cancer

Patient Information

Name: _____ DOB: _____

Phone: _____ MRN: _____

Referring Provider Information

Name: _____

Clinic Name: _____

Phone: _____ Fax: _____

Reason for Referral (Check all that apply)

- ☐ Personal history of cancer concerning for hereditary risk
- ☐ Significant family history of cancer
- ☐ Known family genetic mutation (e.g., BRCA 1 or 2, MLH1, etc.)

Please provide relevant details (e.g., type of cancer, age of onset, known mutations):

***Do genetic test results need to be completed before treatment or surgery can begin?** ☐ Yes ☐ No

Please e-mail the completed referral form and the following documents to mecc.genetics@nmhs.org or fax to 402-354-2520. **Missing information may cause scheduling delays.**

- ☐ Patient Demographics
- ☐ Photo copy of front and back of insurance card
- ☐ Signed Release of Information (ROI)
- ☐ Pathology report (if applicable)
- ☐ Recent clinic note
- ☐ Records are in Cerner (only send referral and signed Release of Information)

Patient Label	
NAME: _____	DOB: _____
FIN: _____	MRN: _____

NOT PERMANENT PART OF MEDICAL RECORD