

## Referral to Genetics

**Please fax to : 01223 281316**

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

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

**Phone number:** \_\_\_\_\_

### Indication for referral

- Personal history of colorectal cancer AND one of the following:*
- Abnormal tumour testing (MSIH or absent IHC)
  - Diagnosed <50
  - Diagnosed <60 AND TILS, signet ring formation or mucinous
  - Endometrial / Ovarian cancer
  - Multiple bowel polyps
  - 2+ relatives with colorectal cancer / endometrial or ovarian cancer

OR

- Personal history of multiple Adenomas (10+)*

Routine / Urgent (if urgent please indicate why): \_\_\_\_\_

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referrer's name: \_\_\_\_\_

Referrer's e-mail: \_\_\_\_\_

Referrer's phone number: \_\_\_\_\_

Referrer's hospital: \_\_\_\_\_