GeneHealth UK

REFERRAL FOR BREAST CANCER GENETIC TESTING

Fax to 01223 281316 or e-mail to Referral@GeneHealthUK.com

Referral to: ____
(name of genetic counsellor – if known)

Patient details:

Name: ____

DOB: ____

Address: ____

Phone number: ____

Insurance details: ____
(company name, membership number and pre-authorisation number if available)

Diagnosed with breast cancer? Yes / No

Indication for referral:

- ☐ Jewish Ancestry
- ☐ Breast Cancer diagnosed ≤age 45
- ☐ Bilateral breast cancer ≤60
- ☐ Triple negative breast cancer
- ☐ Epithelial Ovarian cancer
- ☐ Male breast cancer
- ☐ Parent / child or sibling meeting above criteria
- ☐ Significant Family history

Routine / Urgent): ____
(if urgent, when are results needed?)

Consultant details:

Name and title: ____

Phone number: ____

Email: ____

Hospital/Clinic: ____

Date: ______________________

Clients diagnosed with breast cancer meeting the above criteria should be eligible for insurance-covered genetic testing. Please include insurance details where possible.