

## REFERRAL FOR GENETIC TESTING

Please fax to 01223 281316 or scan and e-mail to [Referral@GeneHealthUK.com](mailto:Referral@GeneHealthUK.com)

Please visit [www.GeneHealthUK.com/referral](http://www.GeneHealthUK.com/referral) for online submission

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

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

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

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

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

### Indication for referral:

*Individuals from families with:*

- Early onset breast, bowel, womb or prostate cancer (before age 50)
- Male breast cancer or ovarian cancer or bilateral breast cancer
- Ashkenazi Jewish ancestry and breast/ovarian/prostate cancer
- An individual with multiple Adenomas/serrated polyps (10+)
- 2+ close relatives with breast cancer
- 2+ close relatives with colorectal or womb cancer
- 3+ close relatives diagnosed with prostate cancer
- Several relatives with colorectal or womb cancer at any age
- Unusual patterns of cancer

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

Consultant Name and Title: \_\_\_\_\_

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

Email: \_\_\_\_\_

Hospital/Clinic: \_\_\_\_\_

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

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