REFERRAL FOR GENETIC TESTING

Please fax to 01223 281316 or scan and e-mail to Referral@GeneHealthUK.com

Please visit 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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