Oregon Health & Science University
Clinical Cancer Genetics Program Referral

Patient Information

Name:___________________________________ DOB:_____/______/________

Phone:(h)_______________________(w)________________________________

Health Plan:_________________________ Member ID Number:_____________

☐PPO ☐EPO ☐POS ☐Other_____________________________

Is preauthorization required for this consult? ☐Yes ☐No

If so, please include authorization/confirmation number _____________________

Indications for referral (check all that apply)

☐Personal history of cancer → diagnosis___________________Age at dx:______

☐Family history of cancer

relation_____________diagnosis___________________Age at dx:______

relation_____________diagnosis___________________Age at dx:______

relation_____________diagnosis___________________Age at dx:______

relation_____________diagnosis___________________Age at dx:______

Referral Information

Referring Provider:____

Address: ____

Phone:__________________ Fax: __________________

Permission to contact patient directly: ☐yes ☐no

Given this patient's personal and/or family history of cancer, I am referring him/her for genetic cancer risk assessment as medically necessary care.

Physician signature:____

Date:___________________

Please fax this referral along with pertinent medical records to (503) 494-6413

Updated 03/12