

**UNC Cancer & Adult Genetics Clinic**

**Tel: 919-843-8724 or 919-445-3364**

**Fax: 919-966-4151**

**Patient Referral Form**

Please fill out **completely to ensure prompt attention** and accurate scheduling for your patient.  
Fax **completed form** along **with patient records** to 919-966-4151, Attention LaTonya.

*(Circle)*

**ROUTINE**

**URGENT**

**PENDING: Surgery / Treatment**

Date of Referral: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Contact Person: \_\_\_\_\_

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

Fax: \_\_\_\_\_

**Completed by UNC Office Staff Only:**

Appointment Date & Time: \_\_\_\_\_

Provider: \_\_\_\_\_

**Cancer Genetics**

- ☐ \_\_\_\_\_ Personal or \_\_\_\_\_ Family history of cancer
- ☐ Breast cancer diagnosis < 45years
- ☐ Breast diagnosis < 60 years and Triple Negative
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Colorectal cancer or Polyps
- ☐ Abnormal IHC or MSI study
- ☐ Polyp # and type \_\_\_\_\_
- ☐ Other cancer \_\_\_\_\_
- ☐ Ashkenazi Jewish ancestry
- ☐ Known cancer gene mutation in family  
Gene / mutation \_\_\_\_\_  
(please attach report)

**For personal history:** Please include clinic notes and relevant labs (clinical diagnosis & pathology report)

**Additional Notes:**

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**Adult General Genetics (Non – Cancer)**

- ☐ Personal history of \_\_\_\_\_
- ☐ \_\_\_\_\_
- Evaluate for:**
- ☐ EDS/ Connective tissue /Joint disorder
- ☐ Marfan syndrome / Aortic Aneurysm
- ☐ Cardiomyopathy / Arrhythmia
- ☐ Neuropathy / CMT
- ☐ Myopathy / Muscle weakness
- ☐ Intellectual disability / Autism
- ☐ Dementia / Cognitive decline
- ☐ Huntington's disease
- ☐ Mitochondrial disorder
- ☐ Other: \_\_\_\_\_
- ☐ Known syndrome/mutation in family  
Gene / mutation \_\_\_\_\_  
(please attach report)

**RECORDS REQUIRED IN ORDER TO SCHEDULE  
APPOINTMENT**

**For personal history:** Please include clinic notes and relevant labs

***Thank you for referring your patient to the Cancer & Adult Genetics Clinic at UNC***

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