



1. **Please fill out this form completely;** all fields are required in order to request a new patient appointment. The patient **will not** be scheduled for an indication of **“Evaluation Genetics”** or **“Non-procreative counseling.”** This is **not** an appropriate referral reason. A specific medical question is **REQUIRED**.
2. **Please include patient demographics.**
3. **This form is not for Ehlers Danlos Syndrome / hypermobility (hEDS) referrals. A separate form must be completed. To obtain a copy, please visit our website: [tinyurl.com/UNC-hEDS](http://tinyurl.com/UNC-hEDS).**

**Referral Information Request**

<b>Date of Referral:</b>	<b>Patient:</b>
<b>DOB:</b>	<b>Phone:</b>

<b>Referring Provider:</b>	<b>Contact Person:</b>
<b>Phone:</b>	<b>Fax:</b>

(Circle)      **ROUTINE**                      **URGENT**

If Urgent please describe: \_\_\_\_\_

**Referral Reason:**

(Circle)      **Cancer Genetics**                      **Adult Genetics (Non- Cancer)**

(Circle)      **Personal History**                      **Family History**

Diagnosis code: \_\_\_\_\_      Medical Description: \_\_\_\_\_

**Please explain: What is the specific question (s) you want addressed in this consultation?**

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