



FAX REFERRAL/ORDER FORM

Attn. RWMC/RIA Tele-genetic counseling scheduling (fax to 720.874.4405)

Date: _____

From: _____ Phone Number: _____

Number of Pages: _____

I am referring the following patient for tele-genetic counseling services.

Name _____ Patient DOB _____

Phone Number(s) _____ Is it okay to leave a message? Yes ___ No ___

Language Preference English Spanish

Referring Physician Name _____

Is this a medical necessity? Yes No

Patient has a current diagnosis or personal history of (please check all that apply):

- Breast Cancer
- Ovarian Cancer
- Colorectal Cancer
- Colorectal Polyps
- Uterine Cancer
- Other
- None

Patient has a family history of (please check all that apply):

- Breast Cancer
- Ovarian Cancer
- Colorectal Cancer
- Colorectal Polyps
- Uterine Cancer
- Other
- None

Other comments: _____

Other physicians to include on communication/reports: _____

Referring MD Signature _____ Date _____

Please include any relevant records (i.e. pathology reports, colonoscopy reports, etc.) For questions or more information, please call 308.630.1740.

Please Note: The information contained in the facsimile message is privileged and confidential information intended only for the review and use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this communication or the information contained herein is strictly prohibited. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE AND RETURN AND/OR DESTROY THE ORIGINAL MESSAGE TO US AT THE ABOVE ADDRESS.

Access this form internally through the *Regional West Intranet > Provider Resources > Genetic Testing Referral Form* or externally at www.rwmc.net > *Departments and Services > Radiology Services.*