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.

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.***