Yale New Haven Health
Smilow Cancer Hospital

Smilow Cancer Genetics and Prevention Referral

Patient name: _____ Patient DOB: _____

Home Phone: _____ Cell: _____ Work: _____ Date: _____

Referred by: _____ Office phone #: _____

Referring Provider's NPI#: _____

Please select the indication for referral below and fax the referral form along with accompanying records to 203-200-1362. Patients will be contacted by our office to initiate the scheduling process.

Is an appointment needed urgently for surgical/treatment decision making? ☐ YES ☐ NO

Referral for Genetic Counseling Please check any and/or all that apply		
Personal History	Family History	
		Breast cancer diagnosis ≤ age 50
		Triple negative (ER-/PR-/Her2-) breast cancer at any age
		Colon, uterine diffuse gastric or renal cancer diagnosis ≤ age 50
		Ovarian, fallopian tube, or primary peritoneal cancer at any age
		Male breast cancer at any age
		Pancreatic cancer (exocrine-type) at any age
		Prostate cancer at any age with at least one of the following: intraductal/cribiform, high - or very - high risk group according to National Comprehensive Cancer Network (NCCN), or metastatic
		Cancers on the same side of the family known to be caused by a single gene mutation (e.g. breast/ovarian/ pancreatic; colon/uterine/ovarian)
		Ashkenazi Jewish ancestry in combination with a personal or family history of breast, ovarian, pancreatic or metastatic/high risk prostate cancer at any age
		Polyps: >10-20 cumulative GI polyps or >5 hamartomatous or juvenile polyps (**procedure and pathology reports <u>required</u> to be sent with referral)**
		Rare tumors or physical findings (e.g. Sebaceous carcinoma/adenoma)
		Any Lynch syndrome related tumor that is MSI-high or mismatch repair deficient by Immunohistochemistry (IHC)
		Known genetic mutation (e.g. *BRCA1, BRCA2, MLH1, RET, CDKN2A, ATM* etc.)

Referral for Cancer Prevention Clinic Appointment	
	Breast Cancer Prevention Clinic
	Cancer Genetics Clinic (MD Geneticist)
	Colon Cancer Prevention Clinic
	Genitourinary Prevention Clinic
	Pancreatic Cancer Detection Clinic

If referral originates from Cancer Genetics at St. Francis Hospital Please Complete Below:

Name of referring genetic counselor: _____

Other referral department (if indicated and different from above): _____

Please note this worksheet should not be used to exclude patients from genetic counseling. There are other factors (e.g. family size, number of female relatives, prophylactic surgeries, adoption) which can limit risk assessment based on family history and should be taken into consideration. There are also other less common hereditary cancer syndromes which are not covered in this worksheet.