Windsong Health
Medical Alliance, PLLC

GENETIC COUNSELING REFERRAL

Patient Name: ___________________________________ Date of Birth: _______________________________

Address: ___________________________________ Phone: ____________________________________

Referring Provider: ________________________________ Practice Name: _____________________________

Genetic counseling prepares your patient for genetic testing results and their implications, and ensures that the right person in the family is tested, the right genetic test is ordered, and the right laboratory is used. Please fax this completed form to 716.626.6312.

Genetic counseling and testing may be considered for individuals with a personal or strong family history of cancer. Patients that have a personal or family history of one or more of the following may be appropriate for genetic counseling:

Breast and Ovarian Cancer

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Three or more relatives with breast or ovarian cancer at any age
- ☐ Triple-negative breast cancer at age 60 or younger
- ☐ Bilateral breast cancer or multiple primary breast cancers
- ☐ Breast and ovarian cancer in the same individual
- ☐ Male breast cancer
- ☐ Ashkenazi Jewish ancestry
- ☐ Known genetic mutation in a family member
- ☐ Other: ____

Colorectal and Endometrial Cancer

- ☐ Colorectal cancer diagnosed at age 50 or younger
- ☐ Endometrial cancer diagnosed at age 50 or younger
- ☐ Three or more relatives with colorectal cancer and/or endometrial cancer
- ☐ Known genetic mutation in a family member

Please provide any additional relevant information for us to assist in the care of your patient:

____

____