IOWA HEALTH CARE

MISSION CANCER + BLOOD

Referral for Oncology Genetic Counseling

Date _____

Patient Name _____

Patient DOB _____ Patient Phone _____

Patient Address _____

Patient Primary Language _____

Patient's Insurance Plan and Policy # (or copy of insurance card) _____

Referring Provider Information

Referring Provider _____

Contact Person _____

Office Phone _____ Office Fax _____

Genetic Counseling Requested (One box must be checked**)**

☐ UIHC Cancer Center- Iowa City

☐ Mission Cancer + Blood

Referral for Genetic Counseling (One box must be checked**)**

☐ Clinically Recommended/Medically Necessary Referral:

Genetic counseling is counseling ordered by a provider (physician/APP) that is necessary for the diagnosis or treatment of disease, illness or injury, without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction or significant pain and discomfort.

☐ Elective Referral:

Elective genetic counseling includes self-referrals and screening services for indications that are not expected to impact the patient's management, or do not meet professional guidelines for standard of care.

Indication for Referral and Question(s) to be Answered

_____

_____

Fax this form, provider note, and other pertinent records (such as past genetic test results, pathology reports, mammogram report, and/or colonoscopy records if applicable) to

UIHC Cancer Center Iowa City: 319-356-8821

Mission Cancer + Blood: 515-235-8372