

Patient Referral Form for Cancer Genetics Service

Page 1 of 2

Forms must be typed

If the referral form is not completed appropriately the referral will not be accepted and the form will be returned.

Patient demographics:

Patient Full Name	
Date of Birth	
Age	
Gender	
Home Address	
Eircode	
Contact Number 1	
Contact Number 2	
First language	
Interpreter required	
Email address	
GP	
GP contact details Address Email Phone	
Carer/ Next of kin name and contact	
Additional needs:	Hearing impaired Intellectual disability Visually impaired Wheelchair used

Referring Team Details:

Referral source hospital	
Referring clinician	
Referring consultant & specialty	
Referring consultant contact details: Address Email Phone	
Medical Council no.	

Patient Referral Form for Cancer Genetics Service

Referral details:	
Date of referral	
Reason for referral Did your patient have genetic testing and does your patient need genetic counselling? Please provide the genetic test results in text box	
Does your patient have a cancer diagnosis? Please complete section 1 and 2. Does your patient have a family history of cancer? Please complete section 2.	

Section 1:

<ul style="list-style-type: none"> Does the patient have a cancer diagnosis/history of cancer/ please specify cancer type 	
<ul style="list-style-type: none"> Age at cancer diagnosis 	
If breast cancer <ul style="list-style-type: none"> Are they pre operation? What is planned surgery date? Will genetic testing change their surgical decision? Are they getting neoadjuvant chemotherapy? Please specify the details of answers to the above in the free text box on your right 	
If colon cancer or endometrial cancer <ul style="list-style-type: none"> Was Immunohistochemistry done?, please provide result Was BRAF or MLH1 Hypermethylation done? please provide results 	
Is tumour testing the reason for referral <ul style="list-style-type: none"> Please provide results Is genetic testing potentially going to change the patient's cancer care – must specify 	

Section 2:

Is there a family member known to carry a cancer gene pathogenic variant (known as mutation)? If yes please provide the details below <ul style="list-style-type: none"> Family member name and date of birth What gene is the mutation in Provide result and where they were tested if possible 	
Additional family history of cancer <ul style="list-style-type: none"> Relation to Patient Cancer Type Age of Diagnosis 	
Known pedigree number	
Additional information	