THOMPSON CANCER SURVIVAL CENTER
Covenant HEALTH

Thompson Cancer Survival Center
Genetics Clinic
1915 White Avenue
Knoxville, TN 37916
Phone: (865) 331-2350
Fax: (865) 374-2088

Genetic Counseling Referral Form

Patient Information:

Last Name:_____ First Name:_____ DOB:_____
Phone Number(s):_____ Email:_____

Are genetic test results needed for surgical planning? ☐ YES ☐ NO

Reason for Referral: Personal and/or family history of cancer. Check all that apply.

Patient	Family Member		Patient	Family Member	
☐	☐	Breast	☐	☐	Stomach
☐	☐	Ovarian	☐	☐	Melanoma
☐	☐	Colon	☐	☐	Thyroid
☐	☐	≥10 Colon Polyps	☐	☐	Kidney
☐	☐	Rectal	☐	☐	Urinary Bladder
☐	☐	Uterine	☐	☐	Prostate
☐	☐	Pancreatic	☐	☐	Other (please specify) _____

Please include the following:

1. **Demographics form**
2. **Front and back of all insurance cards**
3. **Pathology and imaging reports (if applicable)**
4. **Referring physician's last consult note**

Referring/ Authorized Provider's Signature:	Referring Physician:
Phone:	Fax:
Office Contact:	

Thank you! We appreciate your referrals.