**Hereditary Cancer Clinic \*\*\*URGENT\*\*\* Fax Form**

**To:**

**Phone:**  **Fax:**

**Regarding:**  **DOB:**  **/****/**

**From: Melissa Gilstrap, MS, CGC Certified Genetic Counselor**

**Phone: (303) 765-3923 Fax: (303) 765-3884**

**Number of pages (including cover sheet): 3**

**Notes: Faxed: 6/6/2012 8:57 AM**

**Dr.** **,**

**Immunohistochemistry analysis for the mismatch repair proteins was performed on      ’s colorectal tumor specimen and the results were:**

* **MLH1**
* **MSH2**
* **MSH6**
* **PMS2**
* **BRAF V600E mutation**

**These results mean that       is at increased risk to have Lynch syndrome, a hereditary cancer syndrome that leads to an increased risk for colon and other cancers. Genetic counseling and testing for Lynch syndrome is provided by the**  **Hereditary Cancer Clinic. I need you to sign and return the attached physician action form to let us know how you plan to proceed with this information. If you would like** **to be evaluated for Lynch syndrome and other forms of hereditary cancer, please also return the attached referral form. I have also attached information about the screening, Lynch syndrome, and the Hereditary Cancer Clinic.**

**Please call if you have any questions at all.**

**Sincerely,**

**Melissa Gilstrap, MS, CGC**

**MMR IHC SCREENING ABNORMAL RESULT**

**PHYSICIAN ACTION FORM**

**Patient Information:**

**Name:       DOB:   /  /**

**IHC RESULTS WERE:**

* **MLH1**
* **MSH2**
* **MSH6**
* **PMS2**
* **BRAF V600E mutation**

**DUE TO THESE ABNORMAL RESULTS, THE ACTION BELOW HAS BEEN TAKEN BY OUR OFFICE: (PLEASE CHECK ALL THAT APPLY)**

**\_\_\_\_ This patient will be referred to a Centura Hereditary Cancer Clinic and a signed referral form is attached.**

**\_\_\_\_ This patient was referred to another genetic counselor.**

**\_\_\_\_ This patient has already undergone genetic counseling and/or testing.**

**\_\_\_\_ This patient was offered a referral for genetic counseling but is not interested.**

**\_\_\_\_ OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signed,**

**Physician/Health Care Provider (please print) Physician’s group/office**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician signature Date Time Phone**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*PLEASE COMPLETE AND FAX TO MELISSA GILSTRAP AT 303-765-3884.\*\*\***

**Hereditary Cancer Clinic**

**Patient Referral Form**

**Initial HCC appointment will involve:**

* Education on sporadic, familial, and hereditary causes of cancer
* Individual cancer and genetic risk assessment (based on family history)
* Education regarding cancer surveillance and risk factors
* Discussion of the pros and cons of genetic testing (if applicable)

**Follow-up and genetic testing result appointments will be scheduled, if needed.**

**Patient Information:**

**Name:       DOB:   /  /**

**Patient phone numbers:**

**(H)       (W)       (C)**

**This patient:**

**has had cancer in the past. Cancer(s):       Age dx:**

 **X is currently undergoing cancer treatment for colon cancer. Abnormal IHC.**

**has a family history of cancer. Cancer(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **needs to be seen as soon as possible to make treatment decisions.**

**Please provide genetic counseling to this patient. If genetic testing is warranted, and the patient wishes undergo such testing, please coordinate a blood draw and genetic testing.**

**Signed,**

**Physician/Health Care Provider (please print) Physician’s group/office**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician signature Date Time Phone**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*PLEASE FAX TO MELISSA GILSTRAP AT 303-765-3884.\*\*\***

Your patient will be called to schedule an appointment once this referral has been received. You will receive a detailed report from the appointment and a copy of any genetic testing results/results interpretation (if applicable).

**For scheduling department only:**  Appointment location: PAH PKR

Patient insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appt. date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Appt. time: \_\_\_\_\_\_\_\_ AM PM

ICD-9 codes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Faxed to scheduling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial appointment level: 30 minutes 60 minutes TRACKING ONLY (30 mins, no charge)