Referral to Genetic Risk Assessment and Management (GRAM): Oncology Genetic Counseling and High-Risk Management

865-305-GRAM (4726)

Fax: 865-305-6362

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER
Wisdom for Your Life.

Last Name:_____ First Name: _____ MI:____

DOB: _____ Age: _____ Sex: ____ Phone Number_____

Insurance: _____

Referring Provider: _____

****Office Contact Name, Phone Number & Fax Number****

_____

Reason for Referral:_____

_____

Requirements for Referral:

- ☐ *Completed Referral Form
- ☐ Most recent HPI
- ☐ Pathology report for cancer dx
- ☐ Demographics sheet / Insurance
- ☐ Copy of previous genetic testing results report (if applicable)

Will genetic results impact STAT surgical decision?: Y / N

Personal Cancer History

Personal Hx of cancer? Y / N Currently in treatment? Y / N

Cancer type(s): _____ Age(s) at Dx:_____

Family Cancer History

Maternal/Paternal?	Family Member	Type of Cancer	Age at Diagnosis

PLEASE NOTE: We will contact the patient and send the patient paperwork or an electronic link to obtain family history information. As soon as this has been completed and rec'd from the patient we will call and schedule an appointment for genetic counseling. We will then fax the appointment date and time back to the referring provider for your records.

For Office Use

Referral taken by: _____ Today's Date: _____

Appointment date:_____ Appointment Time:_____