

**Patient Referral Form for Cancer Genetics Service**

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**

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

**Section 1:**

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

**Section 2:**

Is there a family member known to carry a cancer gene pathogenic variant (known as mutation)? <b>If yes please provide the details below</b> <ul style="list-style-type: none"> <li>Family member name</li> <li>Family member date of birth</li> <li>What gene is the mutation in</li> <li>Please provide result if possible</li> <li>Where were they tested</li> </ul>	
Known pedigree number	
Additional information	

Please email the completed referral form to [cancergenetics@stjames.ie](mailto:cancergenetics@stjames.ie)