

OhioHealth Physician Group
High Risk Cancer Clinic
Patient Referral Form

High Risk Cancer Clinics are available
at four OhioHealth locations:

- + OhioHealth Grant Medical Center
- + OhioHealth Bing Cancer Center
- + Dublin Cancer Center
- + Westerville Medical Campus

To refer a patient, fax this form to: (614) 533-0353.
For more information, call (614) 566-1600.

Patient Information:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

DOB: _____ Insurance: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

High Risk Referral:

- Known gene mutation such as ATM, BARD1, BRCA1/2, CDH1, PALB2, CHEK2, MSH2, MLH1, MSH6, PMS2, EPCAM RAD51 C, RAD51 D, for example.
- Family history of known gene mutation.
- Family history of female or male breast cancer, ovarian cancer, prostate cancer, colon cancer, or pancreatic cancer in one or more family members.
- Ashkenazi Jewish decent with family history of any cancers as above.
- Chemoprevention and high risk surveillance of Abnormal breast findings such as ADH, ALH, LCIS.
- Dense breasts on imaging.
- History of Chest wall radiation (before age 30 yrs) for treatment of Hodgkin's lymphoma for breast cancer risk surveillance.
- 10 Precancerous Colon Polyps
- Please list the reason for referral if not listed above.

Please send the following items with the referral:

- Demographic sheet (patient's address & insurance info)
- Copy of insurance card (front & back)
- Progress Note relevant to referral
- Copy of all pathology of any relevant biopsies.
- Copy of genetic testing report of patient or family members (if available)
- Imaging reports relevant to referral (mammograms, MRI's, US)
- Last 3 colonoscopy, EGD, EUS reports and pathology

Referring Provider:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

