MUNSON HEALTHCARE

Form #8361 (06/17)

MMC CANCER GENETICS CLINIC CONSULT REQUEST

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Munson Medical Center

FOR REFERRALS - fax this form to 231-392-8485
Contact: 231-392-8537

Date of Referral:____________________

Patient's Legal Name: ______________________________ D.O.B. ______________________

Mailing Address: ____

Daytime Phone: ______________________ Evening Phone: _____________________ Cell: ______________________

MR#______________________ Email:____

Please tell patient to check with their insurance to verify the initial office visit / consultation with a Nurse Practitioner is covered. (CPT code #99215, $250)

ICD CODES:

- ☐ **Z80.9 - Family history of malignancy**
- ☐ **Z85.9 - Personal cancer diagnosis**
- ☐ **Z85.3 - Personal history of breast cancer**

or ICD-10-CM code that corresponds to the patient's cancer diagnosis

Diagnosis and Reason for Consult:

☐ **the patient is waiting to schedule surgery or make surgical decisions based on the results of genetic testing**

☐ **MEDICAL/FAMILY HISTORY FORMS TO PATIENT – by office**

☐ **WITH LETTER BY SCHEDULER ON:** ________________________ **APPOINTMENT DATE/TIME:** __________________

Referring Physician: ______________________________ **Physician Signature:** ______________________________
(printed name)

Referring Physician's Phone: ________________________________ **Fax:** ________________________________

PLEASE FAX ALL REFERRAL FORMS or MEDICAL RECORDS TO THE CANCER GENETICS CLINIC AT THE ABOVE NUMBER

PATIENT ID LABEL