PREMIER
BREAST HEALTH INSTITUTE
OKLAHOMA

REQUEST FOR GENETIC TESTING

North Location
5901 W. Memorial Rd.
Oklahoma City, OK 73142

South Location
8516 S. Portland Ave
Oklahoma City, OK 73159

Phone: (405)768-1970
Fax: (405)438-3993

Patient Name: ____
Last First Middle

DOB: ___________________

I request Genetic Testing for the above patient who meets any of following qualifying criteria:

1. Have you or your family members been diagnosed with cancer at a young age (50 or younger)?
2. Have you or your family members been diagnosed with cancers that are usually rare, like ovarian cancer or male breast cancer?
3. Have you or your family members been diagnosed with more than one cancer?
4. Have 3 or more people, on the same side of your family had cancer?
5. Are you of Ashkenazi Jewish ancestry?
6. Has anyone in your family been found to have a genetic gene mutation?

________________________________ (______)____________________ (______)____________
Provider Name (Print) Phone Number Fax Number

________________________________ ____
Address City State Zip

________________________________ __________________________________
Provider Signature Date

PLEASE SIGN AND RETURN VIA FAX TO (405) 438-3993

FOR OFFICE USE ONLY:

Patient is scheduled with: ____ *on* ______________________

Please send demographics along with this request.