Alberta Health Services

Calgary Hereditary Cancer Clinic Referral

The following complete and legible documents are required to process your request:

- referral *(including family history)*
- relevant patient pathology *(if history of cancer)*

Date of Referral *(yyyy-Mon-dd)*

Patient

Personal Health Number	Interpreter Required ☐ Yes, Language		Date of Birth *(yyyy-Mon-dd)*	
Last Name	First Name	Middle	Gender ☐ M ☐ F	Phone
Address	City/Town	Prov	Postal Code	Location

Physician

Physician Name		
Physician Location/Facility/Address		
Postal Code	Phone	Fax

Expedited/Urgent Referral *(Expedited referrals can only be accepted for two indications: impact on* **immediate** *cancer management or patient is palliative)* ☐ Yes, Explain

Reason for Referral - *Complete section A,B or C*

A. Blood relative with a <u>confirmed mutation</u> in a cancer susceptibility gene.

If known, specify gene _____ and program/ city where testing was done _____

Name of Relative_____ Relationship_____ ☐ Report Attached

B. Assess for specific hereditary cancer syndrome *(page 2 must also be completed)*

☐ Hereditary Breast/Ovarian Cancer *(BRCA1, BRCA2)*
☐ Lynch Syndrome *(Hereditary Nonpolyposis Colorectal Cancer/HNPCC)*
☐ Other *(specify)* _____

C. Other personal/ family history suggesting inherited pattern of cancer *(describe)*

Additional Information Important to this Referral

Hereditary Breast and/ or Ovarian Cancer (HBOC) Ovarian cancer refers to invasive non-mucinous epithelial ovarian cancer; includes cancer of fallopian tubes or primary peritoneal cancer; excludes borderline or low malignant potential ovarian tumors.

Breast Cancer

- ☐ Personal history of breast cancer diagnosed less than or equal to 35.
- ☐ Personal history of bilateral breast cancer; one diagnosed less than or equal to 50.
- ☐ Personal history of breast and ovarian cancer.
- ☐ Personal history of breast cancer less than or equal to 50 AND a family history of breast cancer less than or equal to 50.
- ☐ Personal history of breast cancer AND family history of ovarian cancer diagnosed at any age.
- ☐ Personal history of breast cancer AND two family members with breast cancer; one diagnosed less than or equal to50.
- ☐ Personal history of breast cancer AND two family members with pancreatic adenocarcinoma at any age.
- ☐ Personal history of triple negative breast cancer (ER-ve, PR-ve, Her2-ve) diagnosed less than or equal to age 60.
- ☐ Personal history of male breast cancer diagnosed less than or equal to age 65.
- ☐ Personal history of male breast cancer diagnosed at any age, and a family history of breast or ovarian cancer.
- ☐ Personal history of breast cancer and family history of male breast cancer.
- ☐ Personal history of breast or ovarian cancer and Ashkenazi Jewish Ancestry.
- ☐ Ashkenazi Jewish heritage and one or more close relatives with breast/ ovarian cancer.

Ovarian Cancer

- ☐ Personal history of invasive epithelial ovarian/ fallopian tube/ primary peritoneal cancer at any age.

Pancreatic Cancer

- ☐ Personal history of pancreatic adenocarcinoma at any age AND two or more close relatives with breast/ovarian/pancreatic cancer at any age.

☐ **Unaffected Individual** with a close family member meeting **any** of the above listed criteria ***(please describe in space provided on page 1)***. *Individuals unaffected by cancer are usually not eligible for genetic testing except where a mutation is already known. Family history will be assessed to determine if/ what genetic services are available.*

Lynch Syndrome (Hereditary Non-Polyposis Colorectal Cancer or HNPCC)

Lynch Syndrome related cancers include: colorectal, endometrial, ovarian, gastric, small bowel, gallbladder, bile duct, pancreatic, transitional, cell tumour of kidney, ureter, or bladder; sebaceous gland neoplasm, glioblastoma.

- ☐ Personal history of colorectal or endometrial cancer diagnosed less than or equal to 50.
- ☐ Personal history of two Lynch related cancer diagnoses, including at least one cancer diagnosed less than or equal to 50.
- ☐ Personal history of a Lynch related cancer, and two close family members with Lynch related cancers.
- ☐ Personal history of a Lynch related cancer at any age with MSI-H or IHC deficient result. (report required)

☐ **Unaffected Individual** with a close family member meeting any of the above criteria.

Individuals unaffected by cancer are usually not eligible for genetic testing except where mutation is already known. Family history will be assessed to determine if/ what genetic services are available.

Familial Adenomatous Polyposis (FAP) and other polyposis syndromes

- ☐ Suspected or known diagnosis of FAP or other polyposis syndrome in patient or close relative.
- ☐ Personal history of greater than or equal to 10 polyps (adenomatous, harmartomatous). Pathology report(s) required.

Family History

(for all relatives with cancer, please complete page 2)

Last Name	First Name
Date of Birth (yyyy-Mon-dd) if incorrect or not noted above	

Your Cancer History

Have you ever had cancer? ☐ No ☐ Yes, if yes, what type(s) and at what age(s)

Your Children	Has anyone had cancer?
Number of biological daughters _____	☐ No ☐ Yes
Number of Biological sons _____	☐ No ☐ Yes
Your Brother(s) and Sister(s)	Has anyone had cancer?
Number of full sisters _____	☐ No ☐ Yes
Number of full brothers _____	☐ No ☐ Yes
Number of half-sisters _____ ☐ Same mom ☐ Same dad	☐ No ☐ Yes
Number of half-brothers _____ ☐ Same mom ☐ Same dad	☐ No ☐ Yes
Your Mother's Side	Has anyone had cancer?
Mother: Is she still living? ☐ No ☐ Yes Age/age at death _____	☐ No ☐ Yes
What is her ethnic background? _____	
Grandmother: Is she still living? ☐ No ☐ Yes Age/age at death _____	☐ No ☐ Yes
Grandfather: Is he still living? ☐ No ☐ Yes Age/age at death _____	☐ No ☐ Yes
Your Maternal Aunt(s) and Uncle(s)	Has anyone had cancer?
Aunts: How many do you have? _____	☐ No ☐ Yes
Uncles: How many do you have? _____	☐ No ☐ Yes
Are any of these half-siblings to your mother? ☐ No ☐ Yes, *describe below*	
Father's Side	Has anyone had cancer?
Father: Is he still living? ☐ No ☐ Yes Age/age at death _____	☐ No ☐ Yes
What is his ethnic background? _____	☐ No ☐ Yes
Grandmother: Is she still living? ☐ No ☐ Yes Age/age at death _____	
Grandfather: Is he still living? ☐ No ☐ Yes Age/age at death _____	
Your Paternal Aunt(s) and Uncle(s	Has anyone had cancer?
Aunts: How many do you have? _____	☐ No ☐ Yes
Uncles: How many do you have? _____	☐ No ☐ Yes
Are any of these half-siblings to your father? ☐ No ☐ Yes, *describe below*	

Family Background

Is there any Ashkenazi Jewish ancestry in your family? ☐ No ☐ Yes, *(describe)*

Are you adopted? ☐ No ☐ Yes Were either of your parents adopted? ☐ No ☐ Yes

Previous Cancer Genetic Appointment and/or Genetic Testing

Has anyone in your family had genetic counselling or testing for the family history of cancer?

☐ No ☐ Yes - *if yes, provide the following:*

Full name of relative _____ Relationship to you *(i.e. mother)* _____

Name and/or location Genetics Clinic *(name of clinic, City, Country)* _____

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Family History

Information about <u>all</u> Cancer in the Family *(Including children, brothers, sisters, parents, grandparents, aunts, uncles and cousins).* **If you wish to provide additional information, please attach another sheet.**

First and Last Name	Date of Birth (*or estimated age*) ***yyyy-Mon-dd***	Relationship to you	Mom or Dad's side	Type of Cancer	Age (approx) at Diagnosed	Living or Deceased? *(age)*
i.e. Lila Black	1961-Nov-08	Mom's sister's daughter	Mom's side	Breast	65	Died at 68