Sunnybrook
HEALTH SCIENCES CENTRE

Cancer Genetics and High Risk Program Referral Form

FAX to: 416-480-6002

PATIENT IDENTIFICATION

Patient name: _____

Date of birth (YYYY/MM/DD): _____

☐ Male ☐ Female ☐ Other: _____

Address: _____

City: _____ Postal code: _____

OHIP: _____ Version code: ____

Home tel: _____

Cell #: _____

Work #: _____

Email*: _____

* **Required to send link to the online family history questionnaire (FHQ).** FHQ can be mailed if needed.

Referral date (YYYY/MM/DD): _____

Referring physician: _____

Physician billing #: _____

Address: _____

Tel #: _____

Fax #: _____

Referring physician signature: _____

PLEASE NOTE:

- Most patients will be contacted directly by **email** with a link to complete an online FHQ
- A genetic counsellor will review the completed FHQ
- **Due to the high volume of referrals we may decline to see your patient if upon review of the completed FHQ the criteria below are not met.**

1. PERSONAL history of cancer: ☐ No ☐ Yes, type: _____ Age diagnosed: _____

If breast cancer, did the patient have bilateral mastectomy? ☐ No ☐ Yes

2. CHOOSE ALL REFERRAL CRITERIA THAT APPLY:

☐ Personal and/or family history in close relatives of one or more of the following:

- ☐ Breast cancer at ≤ 35 years.
- ☐ Triple negative breast cancer at ≤ 60 years.
- ☐ Bilateral breast cancer, especially if one or both was diagnosed ≤ 50 years.
- ☐ Ovarian cancer at any age.
- ☐ Both breast cancer and ovarian cancer at any age in the same woman.
- ☐ Male breast cancer at any age.
- ☐ HBOC-related cancers at any age and Ashkenazi Jewish ancestry.
- ☐ Multiple cases of HBOC-related cancers** on the same side of the family – describe cancer history:

_____

- ☐ ≥ 10 adenomatous colon polyps.
- ☐ Colon cancer or endometrial cancer at ≤ 50 years.
- ☐ Two cases of colon cancer and/or endometrial cancer at ≤ 60 years.
- ☐ Multiple primary LS-related cancers*** in the same person, especially if one of both was diagnosed ≤ 50 years.
- ☐ Multiple cases of LS-related cancers*** on the same side of the family – describe cancer history:

_____

☐ Family member with a known mutation in a cancer susceptibility gene (i.e. *BRCA1, BRCA2, MLH1, MSH2, MSH6, TP53*, etc)

Specify gene and mutation: _____

Relative's name: _____ Relationship to patient: _____

Attach genetic report and/or genetic counselling letter, if available.

☐ Other personal or family history suggesting inherited pattern of cancer – describe cancer history:

_____

To inquire about a referral, call 416-480-6835. To inquire about a returned FHQ and/or appointment, call 416-480-5000 Ext. 85336

**HBOC (Hereditary breast and ovarian cancer syndrome)-related cancers include: breast (particularly when diagnosed ≤ 50), ovarian, pancreatic and prostate (Gleason ≥ 7 score).

***LS (Lynch syndrome)-related cancers include: colorectal, endometrial, gastric, ovarian, pancreas, ureter and renal pelvis, biliary tract, brain, small intestinal cancers and sebaceous adenomas.

≤ - less than or equal to
≥ - greater than or equal to

PR 47235
(2018/03/06)

FOR OFFICE USE ONLY: CLINIC: _____

HFN: _____ **DATE (YYYY/MM/DD):** _____ **TIME (h):** _____