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†: _____

†Can we send a family history questionnaire (FHQ) to the patient by email? ☐ Yes ☐ No

Referral date (YYYY/MM/DD): _____

Referring physician:_____

Physician billing #:_____

Address: _____

Tel #: _____

Fax #:_____

Referring physician signature:_____

PLEASE NOTE:

- Most patients will be contacted directly by a mailed or emailed FHQ
- A genetic counsellor will review the returned FHQ
- **Due to the high volume of referrals we may decline to see your patient if upon review of the returned FHQ the criteria below are not met.**

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:

_____

*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.

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

PR 47235
(2016/08/04)

FOR OFFICE USE ONLY: CLINIC:_____

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