GRAND RIVER HOSPITAL

GRAND RIVER REGIONAL CANCER CENTRE

CANCER GENETICS REFERRAL FORM

Fax this form to 519-749-4382, or call 519-749-4370 Ext. 2832

Reason for referral:_____

Has the patient been diagnosed with cancer? NO ☐ YES ☐ **Please specify:**_____

Has the patient consented to cancer genetics referral? YES ☐ NO ☐

Does the patient have special need? NO ☐ YES ☐ (eg. wheel chair, oxygen, interpreter, infection control**) other:**_____.

Is this assessment urgent? NO ☐ YES ☐ (eg. Pt or relative with cancer is dying and needs to bank DNA sample immediately, Pt requires genetic test result to plan surgery – i.e. TAH vs. TAHBSO for benign indication, or treatment – i.e. prophylactic mastectomy vs. adjuvant radiation, chemotherapy/clinical trial selection) **Please specify:**_____

PATIENT INFORMATION

NAME:_____ **D.O.B.** _____ **Male ☐ Female ☐**
(Last, First, Middle Initial) **(yyyy-mm-dd)**

Mailing Address: _____ **Telephone #:** _____

_____ **Alternative Contact:** _____

_____ **Alternative Phone #:** _____

Patient Location (if not at home): Hospital _____ **Hospital Chart #:** _____

Health Card Number _____ **Other:**_____

REQUIRED INFORMATION

Referring physician/surgeon _____ **Telephone#**_____ **Fax** _____

Family physician: _____ **Telephone#**_____ **Fax** _____

Information Accompanying Referral: (please provide as much information as possible)

Referral letter ☐ Pathology ☐ Family member's genetic test result ☐ Other ☐_____

Family History (brief history only, as pt will receive a detailed family history questionnaire to complete prior to appt booking)			
Name (if available) and relationship to patient (i.e. Jane Doe, paternal aunt)	**Primary site** (i.e. breast)	**Age at diagnosis**	**Living or deceased**

- The family history will be assessed by the genetics clinic to evaluate whether a genetic counselling appointment is appropriate.

- A family history questionnaire will be sent to the patient and must be completed and **returned prior to booking an appointment.** Family history questionnaire is also available on line at: **www.grandriverhospital.on.ca/Geneticcounselling**
- Genetic testing may or may not be offered in the course of a genetics consultation, pending eligibility.

Cancer Genetics – Referral Criteria

Risk Factors for Inherited Breast and/or Ovarian Cancer:

1. Multiple cases of breast cancer (particularly where diagnosis occurred at less than 50 years) and/or ovarian* cancer (any age) in the family – especially in closely related relatives in more than one generation.
2. Age at diagnosis of breast cancer less than 35 years.
3. A family member diagnosed with both breast and ovarian* cancer.
4. Breast and/or ovarian* cancer in Jewish families.
5. Family member(s) with primary cancer occurring in both breasts, especially if one or both cancers were diagnosed before age 50.
6. A family member diagnosed with invasive serous ovarian* cancer.
7. Presence of male breast cancer in the family.
8. Family member with an identified BRCA1 or BRCA2 mutation.
9. Presence of other associated cancers or conditions suggestive of an inherited cancer syndrome.

**Includes cancer of the fallopian tubes and primary peritoneal cancer*

Risk Factors for Inherited Colorectal Cancer:

1. Multiple cases in the family of cancers related to the hereditary nonpolyposis colorectal cancer (HNPCC) spectrum with at least one relative affected with colorectal or endometrial cancer. An age of onset less than 50 years, in closely related relatives and in more than one generation would raise the index of suspicion.

Note: *Cancers related to the HNPCC spectrum include: colorectal, gastric, small bowel, primary hepatobiliary, pancreatic, endometrial, ovarian, kidney, ureter, sebaceous carcinoma of the skin and primary brain cancers.*

2. Age at diagnosis of colorectal cancer less than 35 years.
3. Multiple primary cancers in one family member (see 1. above for tumour sites).
4. Family member with familial adenomatous polyposis (FAP), or 10 or more histologically confirmed adenomatous polyps (suggestive of attenuated FAP).
5. Family member with a colonic adenoma or cancer with high microsatellite instability (MSI).
6. Family member with a known mutation causing either HNPCC or FAP.

Other:

1. An unusual clustering of cancers, or atypically young age at diagnosis for that type of cancer, which has raised concern by the patient or health care provider about the possibility of a hereditary/familial cancer syndrome.
2. If uncertain about the appropriateness of a referral or for clarification, please contact the GRRCC genetic counsellor at (519) 749-4370 x2832.