OBSP Requisition for High Risk Screening

1. Client Information (*or affix label*)	
First name	Last name
Date of birth (dd/mmm/yyyy)	OHIP number
Telephone number Secondary telephone number	Address (*including postal code*)

To receive high risk breast screening (*i.e.: annual MRI and mammogram*), women must be **between 30 and 69 and** be at high risk for breast cancer as identified through **Category A OR Category B**, after genetic assessment. **Women with bilateral mastectomies are not eligible**.

Category A: eligible for **direct entry** into the program. To fall under this category, **at least one** of the following criteria must be met (supporting documentation required) :

- ☐ Known carrier of a gene mutation (*e.g. BRCA1, BRCA2 - **fax results with form***)
- ☐ First degree relative of a carrier of a gene mutation (*e.g. BRCA1, BRCA2*), has previously **had** genetic counselling, and has **declined** genetic testing
- ☐ Previously assessed as having a ≥25% lifetime risk of breast cancer on basis of family history (*a genetic clinic must have used **at least one** of the tools below to complete this assessment – **fax results with form***)

  IBIS 10 Year Risk: *BOADICEA 5 Year Risk:*

  IBIS Lifetime Risk: *BOADICEA Lifetime Risk:*
- ☐ Received chest radiation (not chest x-ray) before age 30 and at least 8 years previously (*e.g. as treatment for Hodgkin's Lymphoma*)

OR

Category B: genetic assessment required (*i.e. counselling and/or testing*) to determine eligibility for the program. To fall under this category, **at least one** of the following criteria must be met (supporting documentation required) :

- ☐ First degree relative of a carrier of a gene mutation (*e.g. BRCA1, BRCA2*) and has not had testing or counselling- send relative's results
- ☐ A personal or family history of **at least one** of the following (*please check all that apply*):
  - ☐ Two or more cases of breast cancer and/or ovarian* cancer in closely related blood relatives†
  - ☐ Bilateral breast cancers
  - ☐ Both breast and ovarian* cancer in the same woman
  - ☐ Breast cancer at ≤35 years of age
  - ☐ Invasive serous* ovarian cancer
  - ☐ Breast and/or ovarian* cancer in Ashkenazi Jewish families
  - ☐ An identified gene mutation *(e.g. BRCA1, BRCA2)* in any blood relatives - Please send supporting notes.
  - ☐ Male breast cancer

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

† *Closely related blood relative: 1st degree = parent, sibling, or child; 2nd degree = grandparent, aunt, uncle, niece,* or *nephew*

2. Clinical History	
Date and location of most recent mammogram	Previous breast cancer? ◯ Yes ◯ No
Date and location of most recent MRI (*if done*)	Breast implants? ◯ Yes ◯ No
Previous genetic assessment for inherited breast cancer risk? ◯ Yes (***attach results***) ◯ No	Specify genetic assessment centre

3. Referring Physician	
First and last name	CPSO Number
Address (*including postal code*)	Telephone number
Signature	Date (dd/mmm/yyyy)

By signing this form, you authorize your client to receive screening mammography and MRI (or, if appropriate, screening ultrasound). You also authorize the OBSP to book these screens, additional screens, as well as any follow-up appointments, including imaging tests and biopsies for evaluation of abnormal results. **Fax completed form to the OBSP High Risk Screening Referral Contact in your area**.

OBSP High Risk Screening Program

A) WHO IS ELIGIBLE FOR HIGH RISK SCREENING UNDER THE ONTARIO BREAST SCREENING PROGRAM (OBSP)?

Category A: eligible for **direct entry** into the program *Send all supporting documents*

1. Must be an Ontario resident
2. Must have a valid OHIP number
3. Are between the age of 30 and 69 and **meet one of the following criteria:**
    a. Known to be a carrier of a gene mutation (*e.g. BRCA1, BRCA2*)
    b. First degree relative of a carrier of a gene mutation (*e.g. BRCA1, BRCA2*), has previously **had** genetic counselling, and has **declined** genetic testing
    c. Previously assessed by a genetic clinic (using the IBIS or BOADICEA risk assessment tools) as having a ≥25% lifetime risk of breast cancer on basis of family history
    d. Received chest radiation (not chest x-ray) before the age of 30 and at least 8 years previously

Category B: genetic assessment required (*i.e. counselling and/or testing*) to determine eligibility for the

1. Must be an Ontario resident
2. Must have a valid OHIP number
3. Are between the age of 30 and 69 and **meet one of the following criteria:**
    a. First degree relative of a carrier of a gene mutation (*e.g. BRCA1, BRCA2*) and has **not** had genetic counselling or testing
    b. Has a personal or family history of breast or ovarian cancer suggestive of a hereditary breast cancer syndrome

B) WHAT IF MY CLIENT IS NOT ELIGIBLE?

If the criteria for **neither** Category A or Category B can be met, the woman is not eligible to be screened in the OBSP High Risk Screening Program and this form does **not** need to be faxed to the OBSP.

If this is the case, please ensure that you discuss risk appropriate screening with her.

C) HOW DO I ENROLL AN ELIGIBLE CLIENT?

Fax the completed requisition form to an OBSP High Risk Screening Site in your area. Once the form is received, the OBSP will:

1. Arrange for screening (*i.e. mammography and MRI or ultrasound*) for women who are eligible for direct entry into the high risk program **OR**
2. Refer women on to genetic assessment (*i.e. counselling and/or testing*) to determine if they are eligible for high risk screening

Once screened, the OBSP will recall women annually if their results are normal. If screening results are abnormal, the OBSP will arrange for a diagnostic work-up.

D) WHAT ARE THE IBIS AND BOADICEA TOOLS?

IBIS and BOADICEA are breast risk assessment tools that are **used within genetic clinics** to assess the probability of carrying a gene mutation (*e.g. BRCA1, BRCA2*) and the probability of developing breast cancer.

These tools have been chosen as the standard tools for assessing eligibility for entrance into the OBSP High Risk Screening Program. If a genetic assessment is completed, the healthcare provider will receive results from the genetic clinic.

E) IMPORTANT LINKS

OBSP High Risk Screening Program Information and Referral Contacts

Healthcare provider resources

Cancer Care Ontario (CCO) is an organization committed to ensuring accessible services and communications to individuals with disabilities. To receive any part of this document in an alternate format, please contact CCO's Communications Department at: 1-855-460-2647, TTY (416) 217-1815, or publicaffairs@cancercare.on.ca.

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Please complete to the best of your knowledge

Genetics Assessment Questionnaire- Part 1

Please answer the following questions:

1) What are your main concerns/questions that you would like answered at your genetics appointment?

_____

_____

_____

_____

2) Has anyone in your family ever had genetic counselling? Yes____ No ____

If Yes;

What is their relationship to you? _____

When were they seen? _____

Where were they seen? _____

Was genetic testing offered? Yes_____ No_____ Don't Know _____

Was genetic testing completed? Yes_____ No_____ Don't Know _____

Was a genetic mutation found? Yes _____ No _____ Don't Know _____

3) What is your ethnicity or family country of origin?

Mother's side _____

Father's side: _____

Ashkenazi Jewish? No_____ Yes_____ Mother_____ Father_____

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Please complete to the best of your knowledge

Questionnaire - Part 2

1) **How old were you when you got your period? :** _____ years old.
2) **Have you delivered any babies?** Yes____ No ____

   If yes: date of birth for the first baby: _____

3) **Do you still have periods? Please check box.**

   ☐ Still have regular periods

   ☐ Periods are becoming irregular / I am starting to miss periods

   ☐ I am having hot flashes or other symptoms

4) **Have your periods stopped? Please check box:**

   ☐ stopped completely at age: _____

   ☐ stopped completely because of surgery (complete hysterectomy) with removal of both ovaries at age: _____

   ☐ not sure- have had surgery to remove uterus only, ovaries not removed or have no symptoms.

5) **Have you ever taken hormone replacement therapy / HRT?**
   (i.e. estrogen to stop post-menopausal symptoms, this includes pill, patch, cream (please specify). * This does not include birth control pills.

   a. When did you start? _____

   b. When did you stop? _____

6) **What is your height** (feet/inches or cm) _____

7) **How much do you weigh?** (pounds or kgs) _____

8) **Have you ever had a breast biopsy (had a needle to remove tissue/fluid from your breast or had a surgery to remove a lump from your breast)?**

   When: _____

   What hospital: _____

   Could we have permission to view the report from this biopsy? Yes____ No ____

9) **Do you have Ashkenazi Jewish (Eastern European Jewish) ancestry on either side of your family?**
   Breast cancer genes are more common among people with Ashkenazi Jewish ancestry.

   Yes: _____ No_____

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Please complete to the best of your knowledge

Personal History

YOUR NAME	M/F	**Date of Birth** (M/D/Y)	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast, or none if never had)	**Age at Diagnosis**
Mother's initials + details					
Father's initials + details					
Your children- initials 1.					
2.					
3.					
4.					
5.					
6.					
7.					

Family History

YOUR BROTHERS & SISTERS - initials **Total number of brothers _____** **Total number of sisters _____**	M/F	**Date of Birth** (M/D/Y)	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast, or none if never had)	**Age at Diagnosis**	**# Children** *M*	*F*
1.							
2.							
3.							
4.							
5.							
6.							
7.							

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FAMILY HISTORY

GRANDPARENTS	**Approximate Year of Birth**	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast, or none if never had)	**Age at Diagnosis**
YOUR GRANDMOTHER's initials (on your mother's side)				
YOUR GRANDFATHER's initials (on your mother's side)				
YOUR GRANDMOTHER'S initials (on your fathers side)				
YOUR GRANDFATHER's initials (on your father's side)				

YOUR MOTHER'S BROTHERS & SISTERS- initials **Total number of Aunts on mother's side _____** **Total number of Uncles on mother's side_____**	M / F	**Approximate Year of Birth**	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast, or none if never had)	**Age at Diagnosis**	**# Children** *M*	*F*
1.							
2.							
3.							
4.							
5.							
6.							
7.							

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FAMILY HISTORY

YOUR FATHER'S BROTHERS & SISTERS- initials **Total number of Aunts on your father's side _____** **Total number of Uncles on your father's side _____**	M / F	**Approximate Year of Birth**	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast, or none if never had)	**Age at Diagnosis**	**# Children** *M* *F*	
1.							
2.							
3.							
4.							
5.							
6.							
7.							

OTHER FAMILY MEMBERS diagnosed with cancer eg. Cousins, nieces and nephews, Great-grandparents, great aunts and uncles, grandchildren						
Name (Please Print) Last, First, (Maiden in Brackets) Initials	M/ F	**Approximate Year of Birth**	**Relationship to you and name of parent** *(eg. cousin, John Doe's daughter)*	**If deceased,** *list year or age of death.*	**Cancer Type** (e.g. breast)	**Age at Diagnosis**
1.						
2.						
3.						
4.						
5.						
6.						