GRAND RIVER HOSPITAL
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Grand River Regional Cancer Centre
Cancer Genetics Referral Form

- Please fax this form to 519-749-4382. If you have questions or concerns, please call 519-749-4370, ext. 2832.
- A family history questionnaire **must be completed and submitted with this completed referral form**. The family history questionnaire is available online at:
  https://www.grhosp.on.ca/professionals/chief-of-staffs-office/referral-forms
- Detailed referrals may be processed quicker than less detailed referrals.
- The completed referral and family history will be reviewed by the genetics clinic to determine your patient's eligibility for a genetic counselling appointment.
- Genetic testing may or may not be offered in the course of a genetics consultation, pending eligibility.

Referral Eligibility	
Please complete the checklist on page 2.	
Is this assessment urgent? ☐ No ☐ Yes	Reason and timeframe:
Does the patient have a personal history of cancer? ☐ No ☐ Yes	Please include type (i.e. primary site(s), metastases), age at diagnosis, any concerning pathologic features (please send pathology report):
Does the patient have a family history of cancer? ☐ No ☐ Yes	Please include type (i.e. primary site(s), metastases), age at diagnosis, living or deceased:

Patient Information	
Name (Last, First, Middle Initial):	DOB (yyyy-mm-dd):
Sex: ☐ Male ☐ Female	Address:
Phone number:	Does the patient require an interpreter? ☐ No ☐ Yes
Email address:	Patient consents to receive information by email: ☐ No ☐ Yes
Health card number:	Hospital chart number (if applicable):

Physician Information		
Referring physician:	Phone number:	Fax number:
Primary care provider:	Phone number:	Fax number:

Information Accompanying Referral (Required)
☐ Family Health Questionnaire (mandatory) ☐ Referral letter ☐ Pathology ☐ Family member's genetic test result ☐ Other:

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Cancer Genetic Testing Referral Criteria

Referrals ***must*** meet one or more of the following criteria. **Please check all of the boxes that apply.**

Personal or family history of MULTPLE CANCERS among close relatives on the SAME SIDE of the family:

☐ 2 or more cancers from one of the following groups:
- ☐ breast/ovary/prostate/pancreas
- ☐ colorectal/uterine/ovarian/gastric/GE junction/ureter-renal pelvis/upper GI/pancreas-biliary tree/primary brain/sebaceous neoplasm
- ☐ gastric/breast
- ☐ melanoma/pancreas/primary brain
- ☐ renal/hemangioma/cutaneous lesions (not including basal cell carcinoma)
- ☐ endocrine tumours

☐ Multiple primary cancers in one person
☐ 3 or more close relatives with the same type of cancer
☐ >5 basal cell carcinoma in one individual
☐ Brain tumour ***plus*** any other personal history of cancer, or family history of breast, colon, or sarcoma
☐ History suggestive of colorectal polyposis (≥10 adenoma, ≥5 adenoma plus family history of colon/uterine/brain, multiple fundic gland polyposis, ≥5 serrated polyps, any hamartomatous/other rare polyps)

Personal or family history of a close relative with YOUNG cancer:

☐ Breast, renal, or sarcoma cancer ***≤45 years of age***
☐ Colon, uterine cancer, gastric or gastroesophageal junction cancer ***≤50 years of age***
☐ Basal cell carcinoma ***≤30 years of age***

Personal or family history of a close relative with RARE or STRONG HEREDITARY RISK cancer:

☐ Triple negative breast cancer ***≤60 years of age***
☐ Male breast cancer
☐ Invasive epithelial ovarian cancer, fallopian tube or peritoneal cancer, serous tubal intraepithelial lesions
☐ Ashkenazi Jewish ancestry with a personal/family history of breast, ovarian, colon cancer or GI polyposis
☐ Pancreatic adenocarcinoma
☐ Prostate cancer (≥T3 staging, Grade Group 4 or 5/Gleason Score 8-10), lymph node involvement, PSA ≥20)
☐ Uveal melanoma
☐ Bilateral or multifocal renal cell carcinoma, or non-clear cell pathology
☐ Diffuse gastric cancer
☐ Other rare tumours with suspected hereditary link such as: gastrointestinal stromal tumour, pheochromocytoma, paraganglioma, cribiform-morular variant of papillary thyroid cancer, hepatoblastoma, desmoid <40yrs, hamartomas of retinal pigment epithelium, medullary thyroid cancer, adrenocortical carcinoma, cutaneous leiomyoma. For other rare tumours, please call the genetics clinic prior to referral.

Specific gene mutations (please send supporting documents):

☐ Family member with a known inherited hereditary cancer gene mutation (e.g. BRAC1/2, MLH1/MSH2/MSH6, APC), please specify: _____

☐ Mismatch repair deficient/MSI high tumours (MLH1 deficient tumours require BRAF and promotor methylation studies complete)
☐ Reproductive partner of this patient is a carrier of a cancer gene that is associated with an autosomal recessive condition (i.e. ataxia telangiectasia, Fanconi anemia, constitutional mismatch repair deficiency, and certain polyposis syndromes). Please provide name of reproductive partner, if tested at GRH, or copy of molecular result if tested elsewhere: _____

Include all supporting documentation (e.g. pathology reports, including tumour, polyp and breast biopsies; genetic test results) with the referral

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Please complete to the best of your knowledge

Genetics Assessment Questionnaire

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 this 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.						