Waterloo Wellington
Regional Cancer Program
Ontario Health (Cancer Care Ontario)

# Grand River Regional Cancer Centre
# Cancer Genetics Referral Form

- Please fax this form to 519-749-2025. If you have questions or concerns, please call 519-749-4300, ext. 2832.
- **A FAMILY HISTORY QUESTIONNAIRE (FHQ) SHOULD BE COMPLETED BY THE PATIENT AND SUBMITTED WITH THE REFERRAL FORM.** The family history questionnaire is attached.
- Incomplete referrals (e.g. no FHQ) will not be processed and the referring provider will be notified.
- The completed referral and family history questionnaire 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**?<br>☐ No ☐ Yes | Reason for **urgency** and timeframe (e.g. surgical decision/treatment planning): |
| Does the patient have a personal history of cancer?<br>☐ No ☐ Yes | Please include type, age at diagnosis, and pathology (include pathology report): |
| Does the patient have a family history of cancer?<br>☐ No ☐ Yes | **Please have your patient complete the attached family history questionnaire to the best of their ability including both affected and unaffected relatives.** |

| **Patient Information** | |
|---|---|
| Name (Last, First, Middle Initial): | DOB (yyyy-mm-dd): |
| Preferred Name: | Pronouns: |
| Sex: ☐ Male ☐ Female ☐ Other | Address: |
| Phone number: | Does the patient require an interpreter?<br>☐ No ☐ Yes |
| Email address: | Does patient consent to receive information by email?<br>☐ 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: |
| Referring Provider Signature: | CPSO Number: | |

| **Information Accompanying Referral (Required)** |
|---|
| ☐ Family Health Questionnaire (mandatory) ☐ Referral letter ☐ Pathology ☐ Family member's genetic test result<br>☐ Other: |

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# Hereditary Cancer Genetic Assessment Referral Guidance

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

**Personal and/or Family history of MULTIPLE CANCERS among close relatives on the SAME SIDE of the family:**

*Note: Genetic testing is best initiated in a family member with cancer – they should be referred first if possible.*

☐ 2 or more breast/ovarian/prostate/pancreatic adenocarcinoma
☐ 2 or more breast/gastric
☐ 2 or more colorectal/endometrial/ovarian/gastric/pancreatic adenocarcinoma/ureter/renal pelvis/biliary tract/small bowel/ brain/sebaceous adenomas/sarcoma
☐ 2 or more malignant melanoma/pancreatic adenocarcinoma
☐ Multiple primary cancers in one individual

**Personal and/or Family history of a close relative with YOUNG cancer:**

☐ **Age 45 or younger** with breast or kidney cancer
☐ **Age 50 or younger** with cancer suggestive of Lynch syndrome[2]

[2]colorectal, endometrial, gastric/GE junction, small bowel, pancreas, hepatobiliary, ovarian, renal pelvis/ureter, glioblastoma, sebaceous neoplasm/keratoacanthoma with abnormal mismatch repair immunohistochemistry)

**Personal and/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
☐ Ovarian Cancer
☐ Pancreatic adenocarcinoma
☐ High risk[1] or metastatic prostate cancer

[1] One or more features: T3 (or higher) staging, Grade Group 4 or 5/Gleason 8-10, lymph node involvement, PSA 20 or higher

☐ Abnormal mismatch repair immunohistochemistry on cancer pathology (suggestive of Lynch syndrome)
☐ Bilateral or multifocal renal cell carcinoma, or non-clear cell pathology
☐ Multiple adenomatous gastrointestinal polyps (10 or more at age 60 or younger, or 20 or more at any age)
☐ Pheochromocytoma or paraganglioma
☐ Medullary thyroid cancer

**Cancer Gene Carrier:**

☐ Confirmed hereditary pathogenic/likely pathogenic variant in a blood relative (e.g. BRAC1/2, MLH1/MSH2/MSH6, APC), please specify and include documentation (consult note/genetic test report):

_____

**Ethnicity:**

☐ Individual with breast, colorectal cancer/polyps, or prostate cancer **AND** ancestry with higher risk of hereditary cancer (e.g. Ashkenazi Jewish)

_____

**Include all supporting documentation (e.g. pathology reports, including tumor, polyp and breast biopsies; family member's genetic test results) with the referral.**

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835 King Street West, PO Box 9056
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## Genetics Assessment Questionnaire

**Please answer the following questions:**

**Name:**_____

**Preferred Name:**_____ **Pronouns:**_____

**Has anyone in your family ever had genetic counselling and/or testing?☐Yes ☐ No**
**If yes, please answer the following questions:**

Name of family member: _____

Relationship to you: _____

When and where they were seen: _____

Genetic test result (if done):_____

**What is your ethnicity or family country of origin?**

Mother's side: _____

Father's side: _____

**Do you belong to a population with a higher incidence of hereditary cancer? e.g. Ashkenazi Jewish?** ☐Yes ☐ No Specify _____

**What are your main concerns/questions that you would like addressed at the genetics appointment?**

_____

_____

_____

_____

**Please complete the family history questionnaire to the best of your ability. Age and birthdates can be approximate. Please include all unaffected relatives in addition to affected relatives.** ***It is important to note that sex refers to sex assigned at birth; if this differs from gender please indicate*.**

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# HROBSP ADDENDUM

## (Please only complete if assigned female at birth)

1) **Age at menarche (first menstrual period):**_____years old.

2) **Have you delivered any babies?** ☐ Yes ☐ No
   If yes: Date of birth for first baby: _____

3) **Have you entered menopause? Please check:**
   a. ☐ Still premenopausal/regular cycle,
   b. ☐ Perimenopausal: becoming irregular/starting to miss periods/having hot flashes or other symptoms
   c. ☐ Stopped completely at age: _____
   d. ☐ Had complete hysterectomy with removal of both ovaries at age: _____
   e. ☐ Don't know (had hysterectomy/ablation but ovaries not removed, no symptoms)

4) **Have you ever taken oral contraceptives?** ☐ Yes ☐ No
   If yes: For how many years? _____

5) **Have you ever taken hormone replacement therapy/HRT?** (i.e. estrogen to relieve post-menopausal symptoms, this includes oral/pill, patch, cream (please specify)?
   a. When did you start? _____
   b. When did you stop? _____

6) **Height** (feet/inches or cm) _____**Weight** (pounds or kgs) _____

7) **Have you ever had a mammogram?** ☐ Yes ☐ No
   If yes: Please list when/where_____

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: _____

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| Name (Please Print)<br>Last, First, (Maiden in Brackets) | 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** |
|---|---|---|---|---|---|
| **YOUR NAME** | | | | | |
| **YOUR MOTHER'S NAME** | | | | | |
| **YOUR FATHER'S NAME** | | | | | |
| **YOUR CHILDREN**<br>1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |

| Name (Please Print)<br>Last, First, (Maiden in Brackets)<br>**YOUR SIBLINGS**<br>**(Please specify half siblings)** | 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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| Name (Please Print)<br>Last, First, (Maiden in Brackets) | **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** (on your mother's side) | | | | |
| **YOUR GRANDFATHER** (on your mother's side) | | | | |
| **YOUR GRANDMOTHER** (on your father's side) | | | | |
| **YOUR GRANDFATHER** (on your father's side) | | | | |

| **YOUR MOTHER'S SIBLINGS**<br>**Total # female _____ Total # male _____**<br>Name: Last, First (Maiden in brackets)<br>**(please specify half siblings)** | 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**<br>*M* | *F* |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |

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| **YOUR FATHER'S SIBLINGS**<br>**Total # female:_____ Total # male:_____**<br>Name: Last, First (Maiden in Brackets)<br>**(Please specify half siblings)** | M /F | **Approximate Year of Birth** | **If deceased,** *list year and/or age of death* | **Cancer Type** (e.g. breast, or none if never had) | **Age at Diagnosis** | **# Children**<br>*M* *F* | |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |
| 6. | | | | | | | |
| 7. | | | | | | | |

| **OTHER FAMILY MEMBERS diagnosed with cancer** e.g. Cousins, nieces and nephews, great-grandparents, great aunts and uncles, grandchildren | | | | | | |
|---|---|---|---|---|---|---|
| Name (Please Print)<br>Last, First, (Maiden in Brackets) | M/ F | **Approximate Year of Birth** | **Relationship to you and name of parent** *(e.g. 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. | | | | | | |
| 7. | | | | | | |

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| **OTHER FAMILY MEMBERS continued** | | | | | | |
|---|---|---|---|---|---|---|
| Name (Please Print)<br>Last, First, (Maiden in Brackets) | M/ F | **Approximate Year of Birth** | **Relationship to you and name of parent** *(e.g. cousin, John Doe's daughter)* | **If deceased,** *list year or age of death.* | **Cancer Type** (e.g. breast) | **Age at Diagnosis** |
| 8. | | | | | | |
| 9. | | | | | | |
| 10. | | | | | | |
| 11. | | | | | | |
| 12. | | | | | | |
| 13. | | | | | | |
| 14. | | | | | | |
| 15. | | | | | | |