



GRAND RIVER REGIONAL CANCER CENTRE

Fax this form to 519-749-4381, or call 519-749-4370 Ext. 5720 if any problems with transmission

CANCER GENETICS REFERRAL FORM

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, urgent due to dying patient or family member) 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 _____

Table with 4 columns: Name (if available) and relationship to patient, Primary site, Age at diagnosis, Living or deceased. Includes instructions to advise patient to gather information prior to appointment.

For Office Use Only

Genetic Counsellor: _____ Preferred Date: _____ Time (24hr): _____
(yyyy-mm-dd)

Appointment given by Referral Office:

Date: _____ Time (24hrs): _____ Pt Contacted: _____
(yyyy-mm-dd) (yyyy-mm-dd, initials)

Note that:

- The family history will be assessed by the genetics clinic to evaluate whether a genetic counselling appointment is required. The genetic counselor may contact your patient for more information prior to booking an appointment.
- Genetic testing may or may not be offered in the course of a genetics consultation.
- The patient should be advised to collect as much information about the family history of cancer as possible, prior to the appointment. Depending on waitlist times, the patient may receive a family history questionnaire and personal information questionnaire prior to the appointment.

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, please contact the genetic counsellor, Kathleen Buckley, (519) 749-4300 x5988.

To send a referral, complete this form and fax to 519-749-4381