

Waterloo Regional Health Network (WRHN) Cancer Centre Cancer Genetics Referral Form

- **PROVIDERS:** Please fax to **519-749-2025**. Call 519-749-4300 ext 2832 with questions/concerns.
- **A FAMILY HISTORY QUESTIONNAIRE (FHQ; ATTACHED) SHOULD BE COMPLETED BY THE PATIENT AND SUBMITTED WITH THE REFERRAL FORM.**
- 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 ? <input type="checkbox"/> No <input type="checkbox"/> Yes	REQUIRED: Reason for urgency and timeframe (e.g. surgical decision/treatment planning):	
Does the patient have a personal history of cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes	Please include type, age at diagnosis, and pathology (include pathology report):	
Does the patient have a family history of cancer? <input type="checkbox"/> No <input type="checkbox"/> 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):	
Name you use daily:	What Pronouns do you use:	
Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____ Gender Identity: _____	Address:	
Phone number:	Does the patient require an interpreter or other accommodation? <input type="checkbox"/> No <input type="checkbox"/> Yes; specify _____	
Email address:	Does patient consent to receive information by email? <input type="checkbox"/> No <input type="checkbox"/> 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)		
<input type="checkbox"/> Family Health Questionnaire (mandatory) <input type="checkbox"/> Referral letter <input type="checkbox"/> Pathology <input type="checkbox"/> Family member's genetic test result <input type="checkbox"/> Other:		

Hereditary Cancer Genetic Assessment Referral Guidance

PROVIDERS: 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 syndrome²
²colorectal, 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 risk¹ 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.

PATIENT: Genetic Assessment Questionnaire

Please answer the following questions:

Name: _____

Chosen 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 family's country of origin?

Biological Mother's side: _____

Biological Father's side: _____

Do you belong to a population with a higher incidence of hereditary cancer?

(e.g. Ashkenazi Jewish/Maori?) ☐Yes _____ ☐No _____ Specify: _____

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

PATIENT: Family History Questionnaire Instructions

- Please fill out this form to the best of your ability.
- Ages and birthdates can be approximate.
- Include **all** requested biological/birth family members (even if they have never had cancer).
- For a person's sex, please use their sex assigned at birth.
 - You may also indicate if their gender identity is different from their sex.
- Please give the completed forms back to your health care provider.

They will include them with your referral.

Name (Please Print) Last, First, (Maiden in Brackets)	Sex at Birth Male/ Female	Date of Birth (M/D/Y)	If deceased, <i>list year or age of death.</i>	Cancer Type (e.g. breast/colon, or none if never had)		Age at Diagnosis	
YOUR NAME							
YOUR BIOLOGICAL MOTHER'S NAME							
YOUR BIOLOGICAL FATHER'S NAME							
YOUR BIOLOGICAL CHILDREN							
1.							
2.							
3.							
4.							
5.							
6.							
7.							
Name (Please Print) Last, First, (Maiden in Brackets) YOUR BIOLOGICAL SIBLINGS (Please note any half siblings and from which side)	Sex at Birth Male/ Female	Date of Birth (M/D/Y)	If deceased, <i>list year or age of death.</i>	Cancer Type (e.g. breast/colon, or none if never had)	Age at Diagnosis	# Children <i>Male Female</i>	
1.							
2.							
3.							
4.							
5.							
6.							
7.							

**Waterloo Wellington
Regional Cancer Program**

Ontario Health (Cancer Care Ontario)

Name (Please Print) Last, First, (Maiden in Brackets)	Approximate Year of Birth	If deceased, <i>list year or age of death.</i>	Cancer Type (e.g. breast/colon, or none if never had)	Age at Diagnosis
YOUR GRANDMOTHER (on your <u>mother's</u> side)				
YOUR GRANDFATHER (on your <u>mother's</u> side)				
YOUR GRANDMOTHER (on your <u>father's</u> side)				
YOUR GRANDFATHER (on your <u>father's</u> side)				

YOUR MOTHER'S BIOLOGICAL SIBLINGS Total # female _____ Total # male _____ Name: Last, First (Maiden in brackets) (please specify half siblings)	Sex at Birth Male/ Female	Approximate Year of Birth	If deceased, <i>list year or age of death.</i>	Cancer Type (e.g. breast/colon, or none if never had)	Age at Diagnosis	# Children <i>Male Female</i>	
1.							
2.							
3.							
4.							
5.							
6.							
7.							

YOUR FATHER'S BIOLOGICAL SIBLINGS Total # female: _____ Total # male: _____ Name: Last, First (Maiden in Brackets) (Please specify half siblings)	Sex at Birth Male/ Female	Approximate Year of Birth	If deceased, <i>list year and/or age of death</i>	Cancer Type (e.g. breast/colon, or none if never had)	Age at Diagnosis	# Children	
						Male	Female
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) Last, First, (Maiden in Brackets)	Sex at Birth Male/ Female	Approximate Year of Birth	Relationship to you and name of parent (e.g. <i>cousin, John Doe's daughter</i>)	If deceased, <i>list year or age of death.</i>	Cancer Type (e.g. breast/colon)	Age at Diagnosis
1.						
2.						
3.						
4.						
5.						
6.						
7.						

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

If you were referred for a breast cancer risk assessment, please complete the next page.

BREAST CANCER RISK ADDENDUM

1) How old were you when you had your first period?: _____ years old.

2) Have you ever given birth? ☐ Yes ☐ No

If yes: date of the birth: _____

3) Have you stopped having periods (entered menopause)? Please check:

- a. ☐ Still having regular periods (premenopausal)
- b. ☐ Periods are becoming irregular/having hot flashes or other symptoms (perimenopausal)
- c. ☐ Stopped completely at age: _____
- d. ☐ Had surgery to remove the uterus and both ovaries: _____
- e. ☐ Had surgery to remove the uterus but ovaries not removed (no symptoms)
- f. ☐ Don't know

4) Have you ever taken a birth control pill (oral contraceptives)? ☐ Yes ☐ No

If yes: for how many years? _____ years

5) Have you ever taken hormone replacement therapy/HRT? (For example, estrogen to help with symptoms after menopause, like a pill, patch, or cream)

- a. What kind? _____
- b. When did you start? _____
- c. When did you stop? _____

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

7) Have you ever had a mammogram (X-ray of the breast)? ☐ 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: _____

Thank you for completing the forms. Please return them to your doctor or nurse practitioner.