BC CANCER HEREDITARY CANCER
Provincial Health Services Authority

www.bccancer.bc.ca/hereditary

Hereditary Cancer Program Referral Form

REFERRAL DATE: _____

Fax referral AND attached Family History Form (completed by patient) to:	
☐ **Fraser Health Authority** **(F) 604.851.4720** (T) 604.851.4710 local 645174	☐ **All other BC/Yukon Health Authorities** **(F) 604.707.5931** (T) 604.877.6000 local 672198

Referring Clinician Name: _____ **Billing #:**_____ **Phone:** _____ **Fax:** _____

Copy to/Second Clinician Name: _____ **Billing #:**_____ **Phone:** _____ **Fax:** _____

Patient				
	Personal Health Number	Date of Birth (yyyy-mmm-dd)	BC Cancer ID#:	Gender ☐ M ☐ F ☐ X Pronouns: _____
	Last Name	First Name	Middle	Phone
	Address	City/Town	Postal Code	Email

Interpreter Required? ☐ Yes, language:

Urgent Referral? (impact on **immediate** cancer management or patient is palliative):
☐ Yes, explain: _____
Urgent Timeline: ☐ <1 week ☐ <1 month ☐ <4 months ☐ other: _____ **If patient is ill, store DNA.**

Reason for Referral – *attach letter/relevant medical records for a syndrome/indication that is not listed below*

1. Personal History Criteria - path/test report required if not in BC Cancer chart ***Family History Form with referral if possible***

Age-specific:
- ☐ breast cancer diagnosed ≤ age 35
- ☐ 2 primary breast cancer diagnoses, at least 1 ≤ age 50
- ☐ triple negative (ER- PR- HER2-) breast cancer ≤ age 60
- ☐ breast cancer OR colorectal cancer ≤ age 50 AND no family history known due to adoption
- ☐ colorectal cancer diagnosed ≤ age 40
- ☐ 2 or more colorectal adenomas ≤ age 40
- ☐ colorectal or endometrial cancer ≤ age 50 AND ≥ 5 adenomas
- ☐ 2 Lynch syndrome related diagnoses, at least 1 ≤ age 50
- ☐ diffuse gastric cancer age ≤ 40 *additional HDGC criteria on website
- ☐ renal cancer ≤ age 45
- ☐ biliary tract cancer ≤ age 50 *additional criteria on website

At least 1 of the following diagnoses at any age:
- ☐ Lynch syndrome related cancer with dMMR (IHC def)
- ☐ male breast cancer
- ☐ non-mucinous epithelial ovarian, fallopian tube or peritoneal cancer (includes STIC)
- ☐ pancreatic ductal adenocarcinoma
- ☐ medullary thyroid cancer
- ☐ paraganglioma or pheochromocytoma
- ☐ 2 or more hamartomatous polyps
- ☐ 10 or more colorectal adenomas (cumulative)
- ☐ serrated polyps meeting WHO 2019 criteria
- ☐ Ashkenazi Jewish heritage & personal or family history of breast, ovary, pancreatic cancer

☐ pathogenic gene variant identified via tissue test (e.g. Oncopanel), self-funded genetic test, out-of-province genetics clinic

2. Family History Criteria - on 1 side of the family & may include referred patient ***Family History Form REQUIRED with referral***

- ☐ a close relative with personal history as above
- ☐ 2 close female relatives with breast cancer, both ≤ age 50
- ☐ 2 close relatives with Lynch syndrome cancer, both ≤ age 50
- ☐ 3 breast cancers in close female relatives, at least 1 ≤ age 50
- ☐ 3 or more Lynch syndrome cancers, at least 1 ≤ age 50
- ☐ 3 melanomas in close relatives at any age

DEFINITIONS:
Breast cancer: includes DCIS and excludes LCIS
Lynch syndrome related cancers: colorectal, endometrial, ovarian, gastric, small bowel, hepatobiliary, pancreatic, kidney, ureter, brain tumours, sebaceous gland adenomas, colorectal adenoma ≤ age 40
Adenomas: tubular or sessile serrated; hyperplastic polyps not included
Close relative: children, siblings, parents, aunts, uncles, grandchildren & grandparents.

3. Carrier Testing - confirmed pathogenic variant in family; records required if testing done outside of BC/Yukon

Gene	Clinic/City where relative tested	Relative Name	Relative DOB	How related to patient

4. Re-Assessment seen previously by the Hereditary Cancer Program. Describe reason for re-referral.

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Name:
BCC ID# (if available):
DOB:

Family History **return to the Hereditary Cancer Program (HCP) with Referral Form**

Please answer the following questions about your **blood** relatives (living and deceased) to help us give you the best care. Your best guesses about ages and other details are fine. This information will become part of your health record.

I give consent for this information to be shared with family members referred to the HCP: ☐ Yes ☐ No

Are you adopted? ☐ No ☐ Yes **Were your parents adopted?** ☐ No ☐ Yes, mother ☐ Yes, father

Are your parents related to each other? (e.g. first cousins) ☐ No ☐ Yes – give relationship: _____

Your Children	How many daughters? ____ How many sons? _____ ☐ I have no biological children
Your Brothers and Sisters ☐ None	How many sisters? ____ How many brothers? ____ How many half-sisters? ____ How many half- brothers? _____ ☐ Same mother ☐ Same father
Your Mother's Side ☐ No info	Is your mother alive? ☐ No ☐ Yes What is her current age or age at death? _____ How many aunts do you have? _____ Are any of them your mother's half-sisters? ☐ No ☐ Yes How many uncles do you have? _____ Are any of them your mother's half-brothers? ☐ No ☐ Yes Is your grandmother alive? ☐ No ☐ Yes What is her current age or age at death? _____ Is your grandfather alive? ☐ No ☐ Yes What is his current age or age at death? _____
Your Father's Side ☐ No info	Is your father alive? ☐ No ☐ Yes What is his current age or age at death? _____ How many aunts do you have? _____ Are any of them your father's half-sisters? ☐ No ☐ Yes How many uncles do you have? _____ Are any of them your father's half-brothers? ☐ No ☐ Yes Is your grandmother alive? ☐ No ☐ Yes What is her current age or age at death? _____ Is your grandfather alive? ☐ No ☐ Yes What is his current age or age at death? _____

Your Family's Ethnic/Ancestral Background: please check all that apply

	Africa/ Caribbean	Asia ☐ East ☐ South/Central	Europe/ UK	French Canadian	Indigenous (First Nations, Metis, Inuit)	Jewish ☐ Ashkenazi ☐ Sephardic	Middle East	South and Central America	Other: _____	Don't Know
Mother's mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother's father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father's mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father's father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Previous Cancer Genetics Appointment/Genetic Testing

Has anyone in your family had genetic counselling or genetic testing for the family history of cancer? ☐ No ☐ Yes

If yes, full name of relative(s): _____ Date of Birth or current age (if known): _____

Relationship to you: _____ Name and/or location of genetics clinic: _____

Received Date:

Name:

BCC ID# (if available):

DOB:

Hereditary Cancer Program Family History Form (page 2 of 2)

Have you ever been diagnosed with cancer?	Type of Cancer	Age at Diagnosis	City Where Diagnosed
No ☐ Yes ☐ If yes:			

List of any blood relatives who have had cancer. Please include children, brothers, sisters, parents, grandparents, aunts, uncles, and cousins. Your best guesses about their age and other details are fine. You may add another page if you need more space. Please try to print clearly if completing by hand.

Relative's full name	**Date of Birth or current age**	**Age at Death**	**Relationship to you**	**Mother's or Father's side**	**Type of cancer**	**Age when diagnosed**	**Location when diagnosed**
e.g. Jane Doe	*1941-Nov-08*		*cousin*	*mother's brother's daughter*	*breast*	*65*	*Victoria, BC*

Have you or anyone in your family had any of the following conditions?	No	Yes	Don't Know	If yes, name of your relative and relationship to you
Chronic pancreatitis that lasted longer than 6 months	☐	☐	☐	
Tumour or growth in the pituitary, parathyroid or adrenal gland	☐	☐	☐	
More than 50 moles/nevi (not freckles)	☐	☐	☐	
More than 10 polyps removed from the colon or rectum (bowel)	☐	☐	☐	