

## Hereditary Cancer Program Referral Form

**\*\*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

REFERRAL DATE: \_\_\_\_\_

Referring Clinician Name: \_\_\_\_\_ Billing #: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Copy to/Second Clinician Name: \_\_\_\_\_ Billing #: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

<b>Patient</b>	Personal Health Number	Date of Birth (yyyy-mmm-dd)	BC Cancer ID#:	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> 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: \_\_\_\_\_

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\***

<p><b>Age-specific:</b></p> <p><input type="checkbox"/> breast cancer diagnosed ≤ age 35</p> <p><input type="checkbox"/> 2 primary breast cancer diagnoses, at least 1 ≤ age 50</p> <p><input type="checkbox"/> triple negative (ER- PR- HER2-) breast cancer ≤ age 60</p> <p><input type="checkbox"/> breast cancer OR colorectal cancer ≤ age 50 <b>AND</b> no family history known due to adoption</p> <p><input type="checkbox"/> colorectal cancer diagnosed ≤ age 40</p> <p><input type="checkbox"/> 2 or more colorectal adenomas ≤ age 40</p> <p><input type="checkbox"/> colorectal or endometrial cancer ≤ age 50 <b>AND</b> ≥ 5 adenomas</p> <p><input type="checkbox"/> 2 Lynch syndrome related diagnoses, at least 1 ≤ age 50</p> <p><input type="checkbox"/> diffuse gastric cancer age ≤ 40 *additional HDGC criteria on website</p> <p><input type="checkbox"/> renal cancer ≤ age 45</p> <p><input type="checkbox"/> biliary tract cancer ≤ age 50 *additional criteria on website</p>	<p><b>At least 1 of the following diagnoses at any age:</b></p> <p><input type="checkbox"/> Lynch syndrome related cancer <u>with</u> dMMR (IHC def)</p> <p><input type="checkbox"/> male breast cancer</p> <p><input type="checkbox"/> non-mucinous epithelial ovarian, fallopian tube or peritoneal cancer (includes STIC)</p> <p><input type="checkbox"/> pancreatic ductal adenocarcinoma</p> <p><input type="checkbox"/> medullary thyroid cancer</p> <p><input type="checkbox"/> paraganglioma or pheochromocytoma</p> <p><input type="checkbox"/> 2 or more hamartomatous polyps</p> <p><input type="checkbox"/> 10 or more colorectal adenomas (cumulative)</p> <p><input type="checkbox"/> serrated polyps meeting <a href="#">WHO 2019 criteria</a></p> <p><input type="checkbox"/> Ashkenazi Jewish heritage &amp; personal or family history of breast, ovary, pancreatic cancer</p>
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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\***

<p><input type="checkbox"/> a close relative with personal history as above</p> <p><input type="checkbox"/> 2 close female relatives with breast cancer, both ≤ age 50</p> <p><input type="checkbox"/> 2 close relatives with Lynch syndrome cancer, both ≤ age 50</p> <p><input type="checkbox"/> 3 breast cancers in close female relatives, at least 1 ≤ age 50</p> <p><input type="checkbox"/> 3 or more Lynch syndrome cancers, at least 1 ≤ age 50</p> <p><input type="checkbox"/> 3 melanomas in close relatives at any age</p>	<p><b>DEFINITIONS:</b></p> <p><b>Breast cancer:</b> includes DCIS and excludes LCIS</p> <p><b>Lynch syndrome related cancers:</b> colorectal, endometrial, ovarian, gastric, small bowel, hepatobiliary, pancreatic, kidney, ureter, brain tumours, sebaceous gland adenomas, colorectal adenoma ≤ age 40</p> <p><b>Adenomas:</b> tubular or sessile serrated; hyperplastic polyps <u>not</u> included</p> <p><b>Close relative:</b> children, siblings, parents, aunts, uncles, grandchildren &amp; grandparents.</p>
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**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
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**4. Re-Assessment** seen previously by the Hereditary Cancer Program. Describe reason for re-referral.

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**      How many sisters? \_\_\_\_      How many brothers? \_\_\_\_  
 None      How many half-sisters? \_\_\_\_      How many half- brothers? \_\_\_\_       Same mother  Same father

**Your Mother's Side**      Is your mother alive?  No  Yes      What is her current age or age at death? \_\_\_\_\_  
 No info      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**      Is your father alive?  No  Yes      What is his current age or age at death? \_\_\_\_\_  
 No info      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 <input type="checkbox"/> East <input type="checkbox"/> South/Central	Europe/ UK	French Canadian	Indigenous (First Nations, Metis, Inuit)	Jewish <input type="checkbox"/> Ashkenazi <input type="checkbox"/> Sephardic	Middle East	South and Central America	Other: _____	Don't Know
Mother's mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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: \_\_\_\_\_

Name:

BCC ID# (if available):

DOB:

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

<b>Have you ever been diagnosed with cancer?</b>  No <input type="checkbox"/> Yes <input type="checkbox"/> If yes:	Type of Cancer	Age at Diagnosis	City Where Diagnosed

**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
<i>e.g. Jane Doe</i>	<i>1941-Nov-08</i>		<i>cousin</i>	<i>mother's brother's daughter</i>	<i>breast</i>	<i>65</i>	<i>Victoria, BC</i>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tumour or growth in the pituitary, parathyroid or adrenal gland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
More than 50 moles/nevi (not freckles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
More than 10 polyps removed from the colon or rectum (bowel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	