BC CANCER HEREDITARY CANCER
Provincial Health Services Authority

HEREDITARY CANCER PROGRAM REFERRAL FORM

Date of Referral: _____ (dd/mm/yy)

Referring Physician: _____ Billing #: _____

Phone: (____) _____ Fax: (____) _____

BCCA CHART Number _____

SURNAME _____ GIVEN NAME(S) _____

☐ Female ☐ Male

BIRTHDATE (D/M/Y) _____ HEALTH CARE PLAN No. _____

MAILING ADDRESS _____

CITY / POSTAL CODE _____

HOME PHONE _____ WORK / CELL PHONE _____

INCOMPLETE / ILLEGIBLE FORMS WILL BE RETURNED

Expedited/Urgent Referral?: ☐ No ☐ Yes - approx. timeframe: _____

If yes, reason for urgency: _____

Indicate preferred location for HCP appt:	***FAX completed Referral Form to office noted below:*** *Please do not send paper copy of Referral Form.*
☐ Abbotsford Centre ☐ Surrey – Fraser Valley Centre	• *Fax* 604-851-4720 • *Phone* 604-851-4710 local 645236
☐ Kelowna - Centre for Southern Interior ☐ Prince George – Centre for the North ☐ Vancouver Centre ☐ Victoria – Vancouver Island Centre ☐ Videoconference appt to _____ *(or closest available)*	• *Fax* 604-707-5931 • *Phone* 604-877-6000 local 672198

Is an interpreter required? ☐ No ☐ Yes If yes, which language? _____

Reason for Referral - Please complete section A, B or C.

Note: *Family history will be assessed by HCP staff and triaged to the most appropriate follow-up.*

A. Blood relative with a confirmed mutation of a cancer susceptibility gene

If known, please specify gene _____ and clinic/city where testing was done: _____

Name of Relative _____ **Relationship to Patient** _____

☐ **Report Attached** ***If testing completed out of province, mutation report is required for genetic testing.**

B. Assess for specific hereditary cancer syndrome ***Page 2 must also be completed***

☐ Hereditary Breast/Ovarian Cancer - *BRCA1, BRCA2*
☐ Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer/HNPCC) – *MLH1, MSH2, MSH6, PMS2, EPCAM*
☐ Other (specify): _____

C. Other personal / family history suggesting inherited pattern of cancer – please describe:

_____

_____

HCP Use Only – Date received: _____

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HEREDITARY CANCER PROGRAM REFERRAL FORM *(cont.)*

Patient's Name: _____

Please complete the appropriate section below if this referral is for a specific syndrome.

Note: Family history refers to close relatives on one side of the family and includes the "index" case (referred patient).

Hereditary Breast* and/or Ovarian** Cancer

* breast cancer **includes DCIS** (ductal carcinoma in situ) and **excludes LCIS** (lobular carcinoma in situ)
** ovarian cancer refers to invasive non-mucinous epithelial ovarian cancer; **includes** cancer of the fallopian tubes, primary peritoneal cancer, and STIC (serous tubal intraepithelial carcinoma); **excludes** borderline/LMP ovarian tumours

- ☐ personal history of breast* cancer diagnosed ≤ age 35
- ☐ personal history of breast* cancer diagnosed ≤ age 50 AND no family history known due to adoption
- ☐ personal history of "triple negative" (ER- PR- HER2-) breast cancer diagnosed ≤ age 60
- ☐ personal history of male breast cancer
- ☐ personal history of more than 1 primary breast* cancer diagnosis, at least 1 of which was diagnosed ≤ age 50
- ☐ personal history of ovarian** cancer at any age **(pathology report required)**
- ☐ personal history of both breast* and ovarian** cancer
- ☐ personal history of breast or ovarian cancer and Ashkenazi Jewish heritage
- ☐ family history that includes **1 or more of the following**:
  - ☐ a close relative with personal history as above
  - ☐ Ashkenazi Jewish heritage and 1 or more relatives with breast* cancer and/or ovarian** cancer
  - ☐ 1 case of ovarian** cancer and 1 case of breast* cancer in close female relatives
  - ☐ 2 or more cases of ovarian** cancer in close relatives
  - ☐ 2 cases of breast* cancer in close female relatives, both diagnosed ≤ age 50
  - ☐ 3 or more cases of breast* cancer in close female relatives, with at least 1 diagnosed ≤ age 50

Lynch Syndrome (also known as Hereditary Nonpolyposis Colorectal Cancer/HNPCC)

- ☐ personal history of colorectal cancer diagnosed ≤ age 40
- ☐ personal history of colorectal cancer diagnosed ≤ age 50 AND no family history known due to adoption
- ☐ personal history of a Lynch syndrome[1] related cancer at any age with IHC-deficient/MSI-H result **(report required)**
- ☐ personal history of 2 Lynch syndrome[1] related cancer diagnoses, at least of which was diagnosed ≤ age 50
- ☐ family history that includes:
  - ☐ a close relative with personal history as above, OR
  - ☐ 2 first degree relatives with a Lynch syndrome[1] related cancer, both diagnosed ≤ age 50, OR
  - ☐ 3 or more Lynch syndrome[1] related cancers with at least 1 case diagnosed ≤ age 50

[1] **Lynch syndrome related cancers** include: colorectal, endometrial, ovarian, gastric, small bowel, hepatobiliary, pancreatic, kidney, ureter, brain tumours, sebaceous gland adenomas, or pathologically-confirmed colorectal adenoma ≤ age 40.

Other Hereditary Cancer Syndromes

Please identify specific syndrome(s) and provide all relevant clinical information on which this referral is based. Attach copies of pathology reports or other pertinent investigations as appropriate.

www.bccancer.bc.ca/health-professionals/clinical-resources/hereditary-cancer