



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: _____

<i>Indicate preferred location for HCP appt:</i>	<i>FAX completed Referral Form to office noted below:</i> <i>Please do not send paper copy of Referral Form.</i>
<input type="checkbox"/> Abbotsford Centre <input type="checkbox"/> Surrey – Fraser Valley Centre	<ul style="list-style-type: none"> • Fax 604-851-4720 • Phone 604-851-4710 local 645236
<input type="checkbox"/> Kelowna - Centre for Southern Interior <input type="checkbox"/> Prince George – Centre for the North <input type="checkbox"/> Vancouver Centre <input type="checkbox"/> Victoria – Vancouver Island Centre <input type="checkbox"/> Videoconference appt to _____ <i>(or closest available)</i>	<ul style="list-style-type: none"> • 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:

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 \leq age 35
- personal history of breast* cancer diagnosed \leq age 50 AND no family history known due to adoption
- personal history of "triple negative" (ER- PR- HER2-) breast cancer diagnosed \leq age 60
- personal history of more than 1 primary breast* cancer diagnosis, at least 1 of which was diagnosed \leq age 50
- personal history of ovarian** cancer at any age (**pathology report required**)
- personal history of both breast* and ovarian** cancer
- 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
 - 1 case of male breast* cancer and another family member with breast* cancer or ovarian** cancer
 - 2 or more cases of ovarian** cancer in close relatives
 - 2 cases of breast* cancer in close female relatives, both diagnosed \leq age 50
 - 3 or more cases of breast* cancer in close female relatives, with at least 1 diagnosed \leq age 50

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

- personal history of colorectal cancer diagnosed \leq age 40
- personal history of colorectal cancer diagnosed \leq age 50 AND no family history known due to adoption
- personal history of a Lynch syndrome¹ related cancer at any age with IHC-deficient/MSI-H result (**report required**)
- personal history of 2 Lynch syndrome¹ related cancer diagnoses, at least of which was diagnosed \leq age 50
- family history that includes:
 - a close relative with personal history as above, OR
 - 2 first degree relatives with a Lynch syndrome¹ related cancer, both diagnosed \leq age 50, OR
 - 3 or more Lynch syndrome¹ related cancers with at least 1 case diagnosed \leq age 50

¹Lynch syndrome related cancers include: colorectal, endometrial, ovarian, gastric, small bowel, hepatobiliary, pancreatic, kidney, ureter, brain tumours, sebaceous gland adenomas, or pathologically-confirmed colorectal adenoma \leq 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