HEREDITARY CANCER PROGRAM REFERRAL FORM

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

Referring Physician: ________________________ Billing #: ________________________

Phone: (_____) ___________ Fax: (_____) ___________

If expedited/urgent referral: □ No □ Yes - approx. timeframe: ________________________

If yes, reason for urgency: _______________________________________________________

<table>
<thead>
<tr>
<th>Indicate preferred location for HCP appt:</th>
<th>FAX completed Referral Form to office noted below:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Abbotsford Centre</td>
<td>• Fax 604-851-4720</td>
</tr>
<tr>
<td>□ Surrey – Fraser Valley Centre</td>
<td>• Phone 604-851-4710 local 645236</td>
</tr>
<tr>
<td>□ Kelowna - Centre for Southern Interior</td>
<td>• Fax 604-707-5931</td>
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<tr>
<td>□ Prince George – Centre for the North</td>
<td>• Phone 604-877-6000 local 672198</td>
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<td>□ Vancouver Centre</td>
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<td>□ Victoria – Vancouver Island Centre</td>
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<tr>
<td>□ Videoconference appt to ______________</td>
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<td>(or closest available)</td>
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</table>

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.)

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.*

**Hereditary Breast* and/or Ovarian** Cancer

* breast cancer excludes lobular carcinoma in situ (LCIS). Includes DCIS depending on age & grade – see website for details.

** 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 non-grade 1 breast cancer diagnosed ≤ age 50 AND no family history known due to adoption
- [ ] personal history of “triple negative” breast cancer diagnosed ≤ age 60
- [ ] 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
- [ ] family history that includes 1 or more of the following:
  - Ashkenazi Jewish heritage and 1 or more relatives with breast* cancer and/or ovarian** cancer
  - a close relative with personal history as above
  - 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 ≤ 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 related cancer at any age with IHC-deficient/MSI-H result (report required)
- [ ] personal history of 2 Lynch syndrome related cancer diagnoses, including at least 1 colorectal cancer and a cancer diagnosed ≤ age 50
- [ ] family history that includes:
  - a close relative with personal history as above, OR
  - 2 first degree relatives with a Lynch syndrome related cancer, both diagnosed ≤ age 50 and including at least 1 diagnosis of colorectal cancer, OR
  - 3 or more Lynch syndrome related cancers, involving more than 1 generation, at least 1 case of colorectal cancer, and 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 adenomas ≤ age 40.

**Other Hereditary Cancer Syndromes**

Please identify the 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/screening/health-professionals/hereditary](http://www.bccancer.bc.ca/screening/health-professionals/hereditary)