Hereditary Cancer Program Referral Form

BC CANCER HEREDITARY CANCER
Provincial Health Services Authority

Fax completed forms and any attachments to 604-707-5931

Hereditary Cancer Program
Tel: 604.877.6000 local 672198
Email: hereditarycancer@bccancer.bc.ca
www.bccancer.bc.ca/hereditary

Referral Date: _____

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

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

☐ **Self-Referral -** include Primary Care Provider's information in "Copy to" above if available.

Patient

Personal Health Number	Date of Birth (yyyy-mmm-dd)	Gender ☐ M ☐ F ☐ X Pronouns: _____	
Last Name	First and Middle Name	Phone 1	Phone 2
Address, City, Postal Code:			**Email**

Interpreter Required? ☐ Yes, language: _____

Urgent Referral - Only if impact on ***immediate*** cancer management or patient is palliative. If patient is unwell or prognosis is limited, consider **DNA storage**.

☐ Yes, reason (required): _____

Results required within: ☐ < 1 month ☐ < 3 months ☐ other: _____

Reason for Referral – Select one or more referral categories below and provide short summary of indication
Eligibility criteria are available on the Hereditary Cancer Program website.

☐ **Personal History of Cancer/Polyps -** Attach relevant reports if not available in CAIS/Cerner/CareConnect.
Type(s) of cancer/polyps, age(s) of diagnosis, and relevant details (e.g. bilateral disease, pathology, or cumulative number of polyps):

☐ **Personal History of Pathogenic Variant for Confirmation and/or Follow-up –** Test report required.
eg. from tissue, private pay, out-of-province genetics clinic, clinical trial/research testing

☐ **Family History of Cancer –** May include patient; completed family history form required.
Brief summary (optional):

☐ **Family History of Pathogenic Variant** - Records required if testing occurred outside BC/Yukon

Gene	Clinic/city where testing done *or* HCP family ID	Relative's Name	Relative's Date of Birth	Relationship to referred patient

☐ **Re-assessment** – Patient that was previously seen at HCP
Please describe any new history and/or reason for referral.

☐ **Other**
Please describe or attach supporting letter/medical records.

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Name:
PHN:
DOB:

Family History *Complete these pages and give to your doctor/NP's office to attach to your referral**

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 agree that personal and family history I provide on these forms can be shared with my relatives for their medical care if they are referred to the HCP or another genetics clinic: ☐ 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 sisters does your mother have? ____ Are any of them your mother's half-sisters? ☐ No ☐ Yes How many brothers does your mother 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 sisters does your father have? ____ Are any of them your father's half-sisters? ☐ No ☐ Yes How many brothers does your father 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 ☐ Swedish/ Nordic	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:

PHN:

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:			

<u>List of any blood relatives who have had cancer.</u> 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 started before age 30	☐	☐	☐	
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)	☐	☐	☐	