Genetics Cancer Referral Form

Porcupine Health Unit • Bureau de santé

Referral Date: _____YYYY-MM-DD_____

Is the patient aware that this referral has been made? ☐ **Yes** ☐ **No**

PLEASE NOTE:
Incomplete referrals will be returned to your office. Some referrals may be declined based on referral criteria. Please see page 2 for referral criteria.

A family history questionnaire will be sent to your patient and must be completed prior to booking an appointment.

Is this referral urgent? ☐ **Yes** ☐ **No**

If yes, please indicate reason for urgency: _____

Patient Information			
Name:		DOB: YYYY-MM-DD	Sex:
Health Card #:	Version Code:	Expiry Date: YYYY-MM-DD	
Address:	City:	Postal Code:	
Home Telephone #:	Mobile:	Work:	

Does this patient have a current or past history of cancer? ☐ **Yes** ☐ **No**

If yes, please attach all relevant cancer pathology reports with this referral.

Type of Cancer	Age at Dx

Has a relative tested positive for a cancer susceptibility gene? ☐ **Yes** ☐ **No**

If yes, please attach genetic test report confirming familial mutation.

Name of Relative	Relationship to patient	Gene

Does this patient have a family history suggestive of a hereditary cancer syndrome? ☐ **Yes** ☐ **No**

If yes, please attach all relevant cancer pathology reports with this referral.

Relation to Patient	Cancer Diagnosis(es)	Age(s) of Onset

Referring Health Care Provider		
Name:		Signature:
Telephone #:	Ext.	Fax #:
Address:		
Billing # :		CPSO #:

Please fax the completed form to the Porcupine Health Unit Genetics Clinic at 705-360-4801

REFERRAL CRITERIA

Breast and/or Ovarian Cancer:

1. Multiple cases of breast cancer (particular where diagnosis occurred at less than 50), and/or ovarian cancer (any age) in the family – especially in closely related relatives in more than one generation
2. Age at diagnosis of breast cancer ≤35
3. Triple negative breast cancer ≤60
4. A family member diagnosed with both breast and ovarian* cancer
5. Breast and/or cancer in Jewish families
6. Family member(s) with primary cancer occurring in both breasts, especially if one or both cancers were diagnosed before age 50
7. A family member diagnosed with invasive serous ovarian* cancer
8. Presence of male breast cancer in the family
9. Family member with an identified pathogenic mutation associated with hereditary breast and ovarian cancer

Note: Ovarian cancer includes fallopian tube and primary peritoneal cancers. It excludes mucinous tumours and borderline tumours/ tumours of low malignant potential.

Colorectal Cancer:

1. Multiple cases in the family of cancers related to Lynch syndrome[#] with at least one relative affected with colorectal or endometrial cancer. An age of onset less than 50 years, in closely related relatives and in more than one generation would raise the index of suspicion.
2. Age at diagnosis of colorectal cancer ≤35 years
3. Multiple primary cancers[#] in one family member
4. Family member with familial adenomatous polyposis (FAP), or 10 or more histologically confirmed adenomatous polyps (suggestive of attenuated FAP).
5. Family member with colonic adenoma or cancer with high microsatellite instability (MSI) or deficient expression of mismatch repair genes through immunohistochemistry (IHC)
6. Family member with a known mutation causing either Lynch Syndrome or FAP

Note: Cancers related to Lynch syndrome include: colorectal, gastric, small bowel, hepatobiliary, pancreatic, endometrial, ovarian, kidney, ureter, sebaceous carcinoma of the skin and primary brain cancers.

Other:

1. An unusual clustering of cancers, or atypically young age at diagnosis for that type of cancer, which has raised concern by the patient and health care provider about the possibility of a hereditary cancer syndrome
2. Presence of other associated cancers or conditions suggestive of an inherited cancer syndrome
3. Presence of a pathogenic mutation related to a hereditary cancer syndrome