

Hereditary Cancer Program Mainstreaming: Increasing Access to Hereditary Cancer Genetic Testing

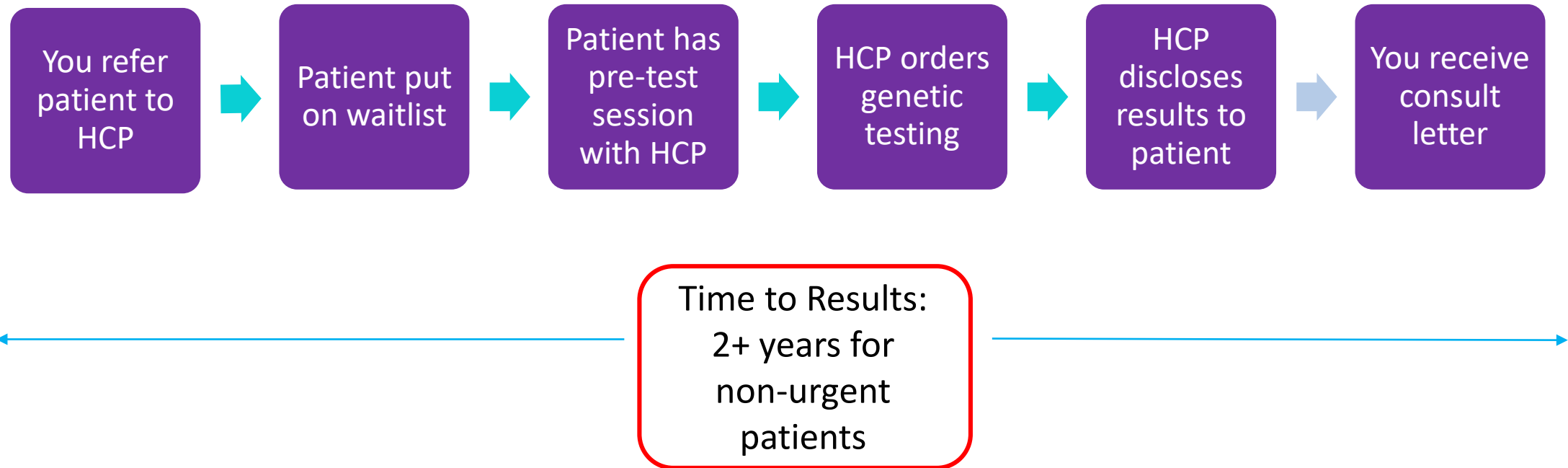


Provincial Health Services Authority

BC Cancer Hereditary Cancer Program

- HCP's Goals:
 - Identify patients and families with hereditary forms of cancer.
 - Facilitate “cascade-testing” for family members once a hereditary cancer mutation is identified in a family.
 - Help high risk individuals access increased screening and risk-reducing procedures.
 - Provide support and updates to mutation carriers as our knowledge of hereditary cancer evolves.

Current pathway to access hereditary cancer genetic testing:



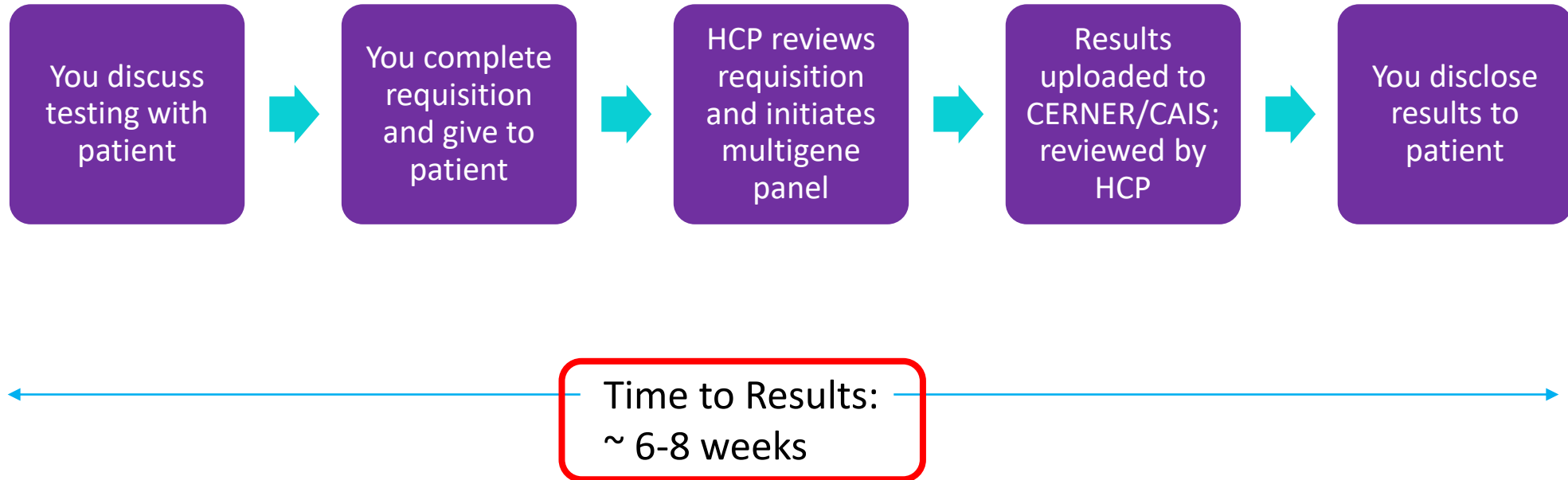
HCP Mainstreaming

Non-genetics clinicians will be able to order hereditary cancer genetic testing for **specific patient populations***.

- No referral to HCP required to access testing
- No family history form required
- Your patients will receive testing and results faster**

*See requisition form at <http://cancergeneticslab.ca/genes/hereditary-cancer-panel/> for current eligibility criteria.


HCP Mainstreaming Pathway:



Is Mainstreaming Right for Your Patient?

- Consider referring your patient to HCP **instead** if:
 - Your patient has many questions or concerns about genetic testing.
 - Your patient may have difficulty understanding or coping with their result.
 - There is a known hereditary cancer mutation in your patient's family.
- Your patient requires genetic counselling regardless of their test results:
 - Patient with multiple primary cancers consistent with a hereditary cancer syndrome
 - Patient with cancer diagnosed at an unusually young age
 - Patient meets clinical criteria for a hereditary cancer syndrome


The Requisition

CANCER GENETICS AND GENOMICS LABORATORY HEREDITARY CANCER MULTI-GENE PANEL				ADDRESSOGRAPH OR PATIENT LABEL	
		BC CANCER DEPT. OF PATHOLOGY AND LABORATORY MEDICINE ROOM 3307 - 600 WEST 10TH AVENUE VANCOUVER BC V5Z 4E6		604-877-6000 EXT 67-2094 FAX: 604-877-6294 MON-FRI 8:30AM-4:30PM WWW.CANCERGENETICSLAB.CA GENETIC.COUNSELLOR@BCCANCER.BC.CA	
PATIENT INFORMATION			REQUESTING PHYSICIAN		
Last Name		First and Middle Names		Name	
Date of Birth (dd/mmm/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non Binary/Other/Not Disclosed		Phone	
PHN		BC Cancer ID	Cerner MRN	Fax	
Email Address			Email Address		
Email Address			Address		
CONSENT TO SHARE RESULTS					
Patient agrees to their results being shared with relatives referred to BC Cancer for genetic testing <input type="checkbox"/> Yes <input type="checkbox"/> No					
If patient is unable to receive their results, it should be disclosed to (or shared with): Name Relationship to patient Contact Phone / Email					
SPECIMEN					
Specimen Type		Collect 1 x 6mL EDTA blood. <small>Store and ship at room temperature using overnight delivery to Cancer Genetics and Genomics Laboratory (address above). Do not refrigerate or freeze.</small>		Collection Date (dd/mmm/yyyy)	
<input checked="" type="checkbox"/> Peripheral Blood					
HEREDITARY CANCER TESTING INFORMATION					
<ul style="list-style-type: none"> This is a blood test to see if your cancer is hereditary. About 1 in 10 cancers are hereditary. If your cancer is hereditary, you will have an appointment with a genetic counsellor. Your test results may have implications for relatives. Your test results may be used to guide your cancer treatment and tell us about new cancer risks. Under the Canadian Genetic Non-Discrimination Act (GNDA), companies (including insurers) and employers cannot ask for your genetic test results or ask you to have genetic testing. Any unused samples may be stored at the BC Cancer Genetics & Genomics Laboratory and may be used to develop new clinical genetic tests in BC. 					
TEST REQUESTED					
<input checked="" type="checkbox"/> Hereditary Cancer Multi-Gene Panel Testing <small>SQHCAGPB</small>					
ANCESTRAL BACKGROUND – SELECT ALL THAT APPLY					
Africa / Caribbean	Asia <input type="checkbox"/> East <input type="checkbox"/> South/Central	Europe / UK	Indigenous (First Nations, Metis, Inuit)	Jewish (Ashkenazi Sephardic)	Middle East
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Specify:					
TESTING INDICATION(S) – SELECT ALL THAT APPLY					
Hereditary Breast and Ovarian Cancer <input type="checkbox"/> Breast cancer ≤ age 35 <input type="checkbox"/> 2 primary breast cancers, at least 1 ≤ age 50 <input type="checkbox"/> Triple negative (ER-PR-HER2-) breast cancer ≤ age 60 <input type="checkbox"/> Breast cancer ≤ age 50 AND no family history known due to adoption <input type="checkbox"/> Ovarian, fallopian tube or peritoneal cancer (non-mucinous epithelial; incl. STIC) <input type="checkbox"/> Male breast cancer			Ashkenazi Jewish Heritage <input type="checkbox"/> Personal or family history of breast, ovarian, pancreatic, high grade prostate cancer		
Pancreatic Cancer <input type="checkbox"/> Pancreatic ductal adenocarcinoma <input type="checkbox"/> Pancreatic neuroendocrine tumour			Other <input type="checkbox"/> ** Approved by Hereditary Cancer Program <input type="checkbox"/> ** Confirmation of pathogenic variant result (include relevant report(s) from tumour testing or clinical trial/research testing)		
Prostate Cancer <input type="checkbox"/> Metastatic prostate cancer			** INDICATION/VARIANT DETAILS (REQUIRED FOR TEST TO PROCEED) <div style="border: 1px solid black; height: 40px;"></div>		
PHYSICIAN SIGNATURE (REQUIRED)			By signing below, I hereby acknowledge that I have informed the patient about the implications of hereditary testing.		
			DATE		
LAB USE ONLY		PB EDTA	Other		


CAGG_CGL_2017 CGL Hereditary Cancer Multi-Gene Panel Requisition
V.1.0 JUNE 2022

<http://cancer geneticslab.ca/genes/hereditary-cancer-panel/>

Sections to Complete: Patient Information


CANCER GENETICS AND GENOMICS LABORATORY HEREDITARY CANCER MULTI-GENE PANEL			ADDRESSOGRAPH OR PATIENT LABEL	
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PATIENT INFORMATION			REQUESTING PHYSICIAN	
Last Name		First and Middle Names	Name	MSC
Date of Birth (dd/mmm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non Binary/Other/Not Disclosed		Phone	Fax
PHN	BC Cancer ID	Cerner MRN	Email Address	
Email Address			Address	
CONSENT TO SHARE RESULTS				
Patient agrees to their results being shared with relatives referred to BC Cancer for genetic testing <input type="checkbox"/> Yes <input type="checkbox"/> No				
If patient is unable to receive their results, it should be disclosed to (or shared with):				
Name		Relationship to patient	Contact Phone / Email	
NOTE: PHYSICIAN SIGNATURE REQUIRED (BELOW)				
SPECIMEN			COPY PHYSICIANS (ALL INFORMATION IS NECESSARY)	
Specimen Type	Collect 1 x 6mL EDTA blood.	Collection Date (dd/mmm/yyyy)	Name	MSC
<input checked="" type="checkbox"/> Peripheral Blood	Store and ship at room temperature using overnight delivery to Cancer Genetics and Genomics Laboratory (address above). Do not refrigerate or freeze.		Address	
HEREDITARY CANCER TESTING INFORMATION			Name	MSC

Sections to Complete: Requesting Physician Information

CANCER GENETICS AND GENOMICS LABORATORY HEREDITARY CANCER MULTI-GENE PANEL			ADDRESSOGRAPH OR PATIENT LABEL	
 <p> BC CANCER BC CANCER DEPT. OF PATHOLOGY AND LABORATORY MEDICINE ROOM 3307 - 600 WEST 10TH AVENUE VANCOUVER BC V5Z-4E6 </p> <p> 604-877-6000 EXT 67-2094 FAX: 604-877-6294 MON-FRI 8:30AM-4:30PM WWW.CANCERGENETICSLAB.CA GENETIC.COUNSELLOR@BCCANCER.BC.CA </p>				
PATIENT INFORMATION			REQUESTING PHYSICIAN	
Last Name		First and Middle Names	Name	MSC
Date of Birth (dd/mmm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non Binary/Other/Not Disclosed		Phone	Fax
PHN	BC Cancer ID	Cerner MRN	Email Address	
Email Address			Address	
CONSENT TO SHARE RESULTS				
Patient agrees to their results being shared with relatives referred to BC Cancer for genetic testing <input type="checkbox"/> Yes <input type="checkbox"/> No				
If patient is unable to receive their results, it should be disclosed to (or shared with):				
Name		Relationship to patient	Contact Phone / Email	
SPECIMEN			COPY PHYSICIANS (ALL INFORMATION IS NECESSARY)	
Specimen Type	Collect 1 x 6mL EDTA blood.	Collection Date (dd/mmm/yyyy)	Name	MSC
<input checked="" type="checkbox"/> Peripheral Blood	Store and ship at room temperature using overnight delivery to Cancer Genetics and Genomics Laboratory (address above). Do not refrigerate or freeze.		Address	
HEREDITARY CANCER TESTING INFORMATION			Name	MSC

NOTE: PHYSICIAN SIGNATURE REQUIRED (BELOW)

Indicate if the patient consents to share their results and who should receive the results if they pass away.

CANCER GENETICS AND GENOMICS LABORATORY HEREDITARY CANCER MULTI-GENE PANEL			ADDRESSOGRAPH OR PATIENT LABEL	
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PATIENT INFORMATION			REQUESTING PHYSICIAN	
Last Name		First and Middle Names	Name	MSC
Date of Birth (dd/mmm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non Binary/Other/Not Disclosed		Phone	Fax
PHN	BC Cancer ID	Cerner MRN	Email Address	
Email Address			Address	
CONSENT TO SHARE RESULTS				
Patient agrees to their results being shared with relatives referred to BC Cancer for genetic testing				
<input type="checkbox"/> Yes <input type="checkbox"/> No				
If patient is unable to receive their results, it should be disclosed to (or shared with):				
Name		Relationship to patient	Contact Phone / Email	
NOTE: PHYSICIAN SIGNATURE REQUIRED (BELOW)				
COPY PHYSICIANS (ALL INFORMATION IS NECESSARY)				
			Name	MSC
			Address	
SPECIMEN				
Specimen Type	Collect 1 x 6mL EDTA blood.		Collection Date (dd/mmm/yyyy)	
<input checked="" type="checkbox"/> Peripheral Blood	Store and ship at room temperature using overnight delivery to Cancer Genetics and Genomics Laboratory (address above). Do not refrigerate or freeze.			
HEREDITARY CANCER TESTING INFORMATION			Name	MSC

Review the Hereditary Cancer Testing Information with your patient.

SPECIMEN			COPY PHYSICIANS (ALL INFORMATION IS NECESSARY)	
Specimen Type	Collect 1 x 6mL EDTA blood. <small>Store and ship at room temperature using overnight delivery to Cancer Genetics and Genomics Laboratory (address above). Do not refrigerate or freeze.</small>	Collection Date (dd/mmm/yyyy)	Name	MSC
<input checked="" type="checkbox"/> Peripheral Blood			Address	
HEREDITARY CANCER TESTING INFORMATION			Name	MSC
<ul style="list-style-type: none">• This is a blood test to see if your cancer is hereditary. About 1 in 10 cancers are hereditary.• If your cancer is hereditary, you will have an appointment with a genetic counsellor.• Your test results may have implications for relatives.• Your test results may be used to guide your cancer treatment and tell us about new cancer risks.• Under the Canadian Genetic Non-Discrimination Act (GNDA), companies (including insurers) and employers cannot ask for your genetic test results or ask you to have genetic testing.• Any unused samples may be stored at the BC Cancer Genetics & Genomics Laboratory and may be used to develop new clinical genetic tests in BC.			Address	
			Name	MSC
			Address	
TEST REQUESTED				
<input checked="" type="checkbox"/> Hereditary Cancer Multi-Gene Panel Testing <small>SQHCAGPB</small>				
ANCESTRAL BACKGROUND – SELECT ALL THAT APPLY				

The patient does not need to sign a consent form, but you must confirm and document their informed consent before proceeding.

An Important Note about Informed Consent...

- **You are responsible for ensuring that the patient gives their informed consent:**
 - Do they understand the purpose of the testing?
 - Do they understand the possible results?
 - Do they understand their potential implications for themselves AND their relatives?
- The patient does not need to sign a consent form.
 - Document the patient's verbal consent in their chart.
- Patients who have concerns about proceeding with genetic testing should be referred to HCP.

If possible, provide ancestry information.

SPECIMEN			Name				
Specimen Type <input checked="" type="checkbox"/> Peripheral Blood	Collect 1 x 6mL EDTA blood. <small>Store and ship at room temperature using overnight delivery to Cancer Genetics and Genomics Laboratory (address above). Do not refrigerate or freeze.</small>	Collection Date (dd/mmm/yyyy)	MSC				
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			Address				
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ANCESTRAL BACKGROUND – SELECT ALL THAT APPLY							
Africa / Caribbean	Asia <input type="checkbox"/> East <input type="checkbox"/> South/Central	Europe / UK	Indigenous (First Nations, Metis, Inuit)	Jewish <input type="checkbox"/> Ashkenazi <input type="checkbox"/> Sephardic	Middle East	South / Central America	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Specify:
TESTING INDICATION(S) – SELECT ALL THAT APPLY							
Hereditary Breast and Ovarian Cancer <ul style="list-style-type: none"> <input type="checkbox"/> Breast cancer ≤ age 35 <input type="checkbox"/> 2 primary breast cancers, at least 1 ≤ age 50 <input type="checkbox"/> Triple negative (ER-PR-HER2-) breast cancer ≤ age 60 <input type="checkbox"/> Breast cancer ≤ age 50 AND no family history known due to adoption <input type="checkbox"/> Ovarian, fallopian tube or peritoneal cancer (non-mucinous epithelial; incl. STIC) <input type="checkbox"/> Male breast cancer Pancreatic Cancer <ul style="list-style-type: none"> <input type="checkbox"/> Pancreatic ductal adenocarcinoma <input type="checkbox"/> Pancreatic neuroendocrine tumour Prostate Cancer <ul style="list-style-type: none"> <input type="checkbox"/> Metastatic prostate cancer 			Ashkenazi Jewish Heritage <ul style="list-style-type: none"> <input type="checkbox"/> Personal or family history of breast, ovarian, pancreatic, high grade prostate cancer Other <ul style="list-style-type: none"> <input type="checkbox"/> ** Approved by Hereditary Cancer Program <input type="checkbox"/> ** Confirmation of pathogenic variant result (include relevant report(s) from tumour testing or clinical trial/research testing) 				
			**INDICATION/VARIANT DETAILS (REQUIRED FOR TEST TO PROCEED)				
PHYSICIAN SIGNATURE (REQUIRED)			By signing below, I hereby acknowledge that I have informed the patient about the implications of hereditary testing.				
			DATE				
LAB USE ONLY	PB EDTA	Other					

You must select at least one applicable testing indication.


SPECIMEN			Name				
Specimen Type <input checked="" type="checkbox"/> Peripheral Blood	Collect 1 x 6mL EDTA blood. <small>Store and ship at room temperature using overnight delivery to Cancer Genetics and Genomics Laboratory (address above). Do not refrigerate or freeze.</small>	Collection Date (dd/mmm/yyyy)	MSC				
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LAB USE ONLY	PB EDTA	Other					

You must sign and date the form.

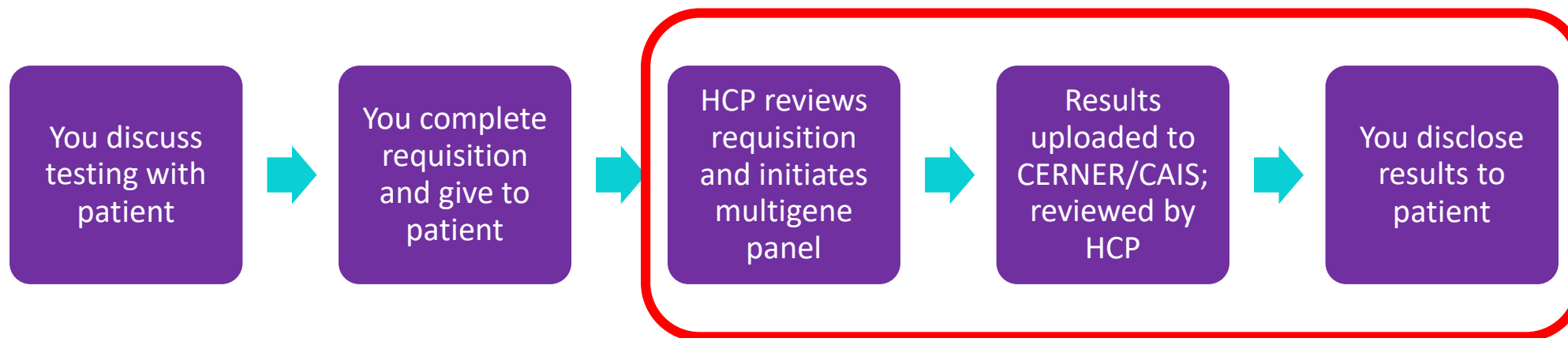
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PHYSICIAN SIGNATURE (REQUIRED)			By signing below, I hereby acknowledge that I have informed the patient about the implications of hereditary testing.				
			DATE				
LAB USE	PB EDTA	Other					
ONLY							

The Requisition

- Once completed, give the requisition to the patient.
- The patient can bring the requisition to any blood lab.
- No fasting or special preparation required.

CANCER GENETICS AND GENOMICS LABORATORY HEREDITARY CANCER MULTI-GENE PANEL				ADDRESSOGRAPH OR PATIENT LABEL			
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PATIENT INFORMATION				REQUESTING PHYSICIAN			
Last Name		First and Middle Names		Name		MSC	
Date of Birth (dd/mmm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non Binary/Other/Not Disclosed			Phone		Fax	
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Email Address				Address			
CONSENT TO SHARE RESULTS							
Patient agrees to their results being shared with relatives referred to BC Cancer for genetic testing <input type="checkbox"/> Yes <input type="checkbox"/> No							
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SPECIMEN							
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PHYSICIAN SIGNATURE (REQUIRED)				By signing below, I hereby acknowledge that I have informed the patient about the implications of hereditary testing.			
				DATE			
Lab Use ONLY	PB EDTA	Other					

HCP Involvement and Support



HCP will:

- Review all requisitions.
- Review all reports.
- Create reflex referrals to HCP for patients with positive results or concerning VUS.
- Notify you when the report is ready and whether we've referred the patient to HCP.
- Answer questions/provide support throughout testing process.

How will you know if your patient needs an HCP referral?

- **HCP will contact you by email when the result is ready and let you know if we've referred the patient to our program.**
- **Consider referring your patient to HCP regardless of their result if:**
 - **You are still concerned about their hereditary cancer risk:**
 - Patient with multiple primary cancers consistent with a hereditary cancer syndrome
 - Patient with cancer diagnosed at an unusually young age
 - Patient meets clinical criteria for a hereditary cancer syndrome
 - **Your patient requires further support understanding or coping with their genetic testing results.**

An Important Note about VUS...

- **Do not alter cancer screening or management!**
- Carrier testing is generally not offered to relatives.
- Most are harmless variations in the genetic code.
- Patient can contact HCP every 1-2 years to request a variant review.

What if my patient does not wish to have genetic testing right now?

- Consider offering DNA storage to your patient.
 - This will help ensure that DNA is available for testing at a later date.
 - See HCP's DNA storage package:
 - http://www.bccancer.bc.ca/coping-and-support-site/Documents/Hereditary%20Cancer%20Program/HCP_Form-UrgentDNARequisitionConsentForm.pdf

HCP Mainstreaming – Ordering Physician Checklist

- Pre-test:
 - Discuss genetic testing with patient and confirm their consent to proceed.
 - Complete requisition and give it to the patient.
 - Document your discussion with the patient in their chart.

HCP Mainstreaming – Ordering Physician Checklist

- Post-test:

- Review report in CERNER/CAIS.

- Disclose result to patient.

- Document your discussion with the patient in their chart.

Questions?

Contact the HCP Lab Genetic Counsellor:

- genetic.counsellor@bccancer.bc.ca



Provincial Health Services Authority