BC CANCER HEREDITARY CANCER
Provincial Health Services Authority

www.bccancer.bc.ca/hereditary

Hereditary Cancer Program Referral Form

REFERRAL DATE: _____

****Fax page 1 (and completed Family History pages if required) to:**

☐ **Fraser Health Authority**	☐ **All other BC/Yukon Health Authorities**
(F) 604.851.4720	**(F) 604.707.5931**
(T) 604.851.4710 local 645174	(T) 604.877.6000 local 672198

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

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

Patient				
	Personal Health Number	Date of Birth (yyyy-mmm-dd)	BC Cancer ID#:	Gender ☐ M ☐ F ☐ X Pronouns: _____
	Last Name	First and Middle Name	Phone 1	Phone 2
	Address	City/Town	Postal Code	Email

Interpreter Required? ☐ Yes, language:

Urgent Referral? (impact on **immediate** cancer management or patient is palliative):
☐ No ☐ Yes, explain: _____
Urgent Timeline: ☐ <1 week ☐ <1 month ☐ other: _____ **If patient is ill, store DNA.**

Reason for Referral – *Select 1 or more of the following indications.*

☐ **Personal History** – attach pathology/other relevant report(s) if not available in CAIS/Cerner/Care Connect

Age-specific diagnoses:
- ☐ breast cancer ≤ age 35
- ☐ 2 primary breast cancers, at least 1 ≤ age 50
- ☐ triple negative (ER- PR- HER2-) breast cancer ≤ age 60
- ☐ breast cancer OR colorectal cancer ≤ age 50 AND no family history known due to adoption
- ☐ colorectal cancer ≤ age 40
- ☐ 2 or more colorectal adenomas ≤ age 40
- ☐ colorectal or endometrial cancer ≤ age 50 AND ≥ 5 adenomas
- ☐ 2 Lynch syndrome-related diagnoses, at least 1 ≤ age 50
- ☐ diffuse gastric cancer ≤ age 50 *additional HDGC criteria on website
- ☐ renal cancer ≤ age 47
- ☐ biliary tract cancer ≤ age 50 *additional criteria on website

At least 1 of the following diagnoses at any age:
- ☐ ovarian, fallopian tube or peritoneal cancer (non-mucinous epithelial; includes STIC)
- ☐ metastatic prostate cancer
- ☐ pancreatic ductal adenocarcinoma
- ☐ pancreatic neuroendocrine tumour
- ☐ Ashkenazi Jewish heritage & personal or family history of breast, ovary, pancreatic, high-grade prostate cancer
- ☐ male breast cancer
- ☐ dMMR (IHC def) Lynch syndrome related cancer
- ☐ ≥ 10 colorectal adenomas (cumulative)
- ☐ ≥ 2 hamartomatous polyps
- ☐ serrated polyps meeting WHO 2019 criteria
- ☐ medullary thyroid cancer
- ☐ paraganglioma or pheochromocytoma

☐ pathogenic gene variant result – for confirmation and/or follow-up (eg. from tissue, private pay, out-of-province genetics clinic, clinical trial/research testing)

☐ **Family History** - may include patient; ***Family History pages REQUIRED with referral***

- ☐ a close relative with personal history as selected above
- ☐ breast and ovarian cancer in close relatives
- ☐ 2 close female relatives with breast cancer, both ≤ age 50
- ☐ 2 close relatives with Lynch syndrome cancer, both ≤ age 50
- ☐ 3 breast cancers in close female relatives, at least 1 ≤ age 50
- ☐ 3 or more Lynch syndrome cancers, at least 1 ≤ age 50
- ☐ 3 melanomas in close relatives at any age

DEFINITIONS:
Breast cancer: includes DCIS and excludes LCIS
Lynch syndrome related cancers: colorectal, endometrial, ovarian, gastric, small bowel, hepatobiliary, pancreatic, kidney, ureter, brain tumours, sebaceous gland adenomas, colorectal adenoma ≤ age 40
Adenomas: tubular or sessile serrated; hyperplastic polyps not included
Close relative: children, siblings, parents, aunts, uncles, grandchildren & grandparents. Can include more distant relatives if appropriate.

☐ Approved by Hereditary Cancer Program

☐ **Carrier Testing** - confirmed pathogenic variant in family; records required if testing done outside of BC/Yukon

Gene	Clinic/City where relative tested	Relative Name	Relative DOB	How related to patient

☐ **Re-Assessment**; describe reason for re-referral

☐ **Other Indication**; describe or attach letter/medical records

Date Received at HCP:

Version: October 2021

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Provincial Health Services Authority

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 give consent for this information to be shared with family members referred to the HCP: ☐ 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	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)	☐	☐	☐	