HEREDITARY CANCER PROGRAM REFERRAL FORM

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

Referring Physician: ____________________ Billing #: ____________________

Phone: (____) ____________________ Fax: (____) ____________________

INCOMPLETE / ILLEGIBLE FORMS WILL BE RETURNED

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>
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<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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<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 program/city where testing was done: ____________________
Name of Relative ____________________ ☐ Report Attached

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)
☐ Other (specify): ____________________

C. Other personal / family history suggesting inherited pattern of cancer – please describe:
__________________________________________________________________________
__________________________________________________________________________

BC Cancer Agency – Hereditary Cancer Program Referral
October 2012
HEREDITARY CANCER PROGRAM REFERRAL FORM (cont.)

Patient’s Name: ________________________________

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 or primary peritoneal cancer; **excludes** borderline/LMP ovarian tumours

- personal history of breast* cancer diagnosed ≤ age 35
- personal history of ovarian** cancer at any age *(pathology report required)*
- breast* cancer and/or ovarian** cancer in Ashkenazi Jewish families
- personal/family history that includes **one or more of the following:**
  - personal history or close family member diagnosed with both breast* and ovarian** cancer
  - personal history of more than 1 primary breast* cancer diagnosis, at least 1 of which was diagnosed ≤ age 50
  - 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
  - 3 or more 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/HNPCC

- personal history of colorectal cancer diagnosed ≤ age 40
- personal history of colorectal cancer diagnosed ≤ age 50 with MSI-H or IHC deficient result *(report required)*
- personal history of endometrial cancer diagnosed ≤ age 50 with MSI-H or IHC deficient result *(report required)*
- personal history of, or close family member with, 2 or more primary HNPCC-related cancer diagnoses¹, at least one of which was diagnosed ≤ age 50, and including at least one diagnosis of colorectal cancer
- family history includes 2 first degree relatives with HNPCC-related cancer, both diagnosed ≤ age 50 and including at least one diagnosis of colorectal cancer
- family history includes 3 or more cases of HNPCC-related cancers¹, involving more than one generation, with at least one case of colorectal cancer, and at least one case diagnosed ≤ age 50

¹ HNPCC-related cancers include: colorectal, endometrial, ovarian, gastric, small bowel, hepatobiliary, pancreatic, kidney, ureter, sebaceous gland adenomas, brain tumours, or a history of one or more pathologically confirmed colorectal adenomas ≤ age 40.

### Other Hereditary Cancer Syndromes

*Please identify the specific syndrome and provide all relevant clinical information on which this referral is based. Attach copies of pathology reports or other pertinent investigations as appropriate.*

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www.screeningbc.ca/hereditary