Sunnybrook
HEALTH SCIENCES CENTRE

Cancer Genetics and High Risk Program Referral Form

FAX to: 416-480-5859

REFERRAL DATE (YYYY/MM/DD):_____

First name:_____
Last name:_____
Date of birth:_____ (YYYY/MM/DD) ☐ Male ☐ Female ☐ _____
Pronouns: _____
Address: _____
_____
Health card:_____ Version code: _____
Preferred tel: _____
Email*: _____
*** Required to send link to the online family history questionnaire (FHQ).** FHQ can be mailed if needed.

PATIENT IDENTIFICATION

Referring physician:_____ Referring physician signature:_____
Physician billing number:_____ Address:_____ Tel:_____ Fax: _____

PLEASE NOTE:
- Most patients will be contacted directly by **email** with a link to complete an online FHQ
- **We may decline to see your patient upon review of the completed FHQ if referral and/or genetic assessment criteria are not met.**

Attach the most recent mammogram with breast density to be included in the breast cancer risk assessment for eligible female patients.

☐ **URGENT:** ☐ No ☐ Yes (please provide reason): _____

1. PERSONAL history of cancer: ☐ No ☐ Yes, type: _____ Age diagnosed: _____

If breast cancer, did the patient have bilateral mastectomy? ☐ No ☐ Yes

2. CHOOSE ALL REFERRAL CRITERIA THAT APPLY:

☐ For hereditary cancer testing based ONLY on potential for an approved targeted therapy based on germline status (i.e. no relevant family history/does NOT meet any below referral criteria): ☐ No ☐ Yes:_____

☐ Family member with a known pathogenic or likely pathogenic variant (mutation) in a cancer susceptibility gene *(e.g. ATM, BRCA1, CHEK2, FH, MSH6, RAD51D, TP53, etc)*. **Attach genetic report and/or genetic counselling letter, if available.**
Specify gene/mutation: _____ Relative's name/genetic number: _____ Relationship to patient:_____

☐ PERSONAL and/or FAMILY history in CLOSE RELATIVES (same side of the family) of one or more of the following:

BREAST / OVARIAN / PANCREATIC / PROSTATE cancer
- ☐ Breast cancer age 45 or younger OR age 50 or younger with limited family structure (e.g. adoption).
- ☐ Triple negative breast cancer age 60 or younger.
- ☐ Bilateral breast cancer, especially if one was diagnosed age 50 or younger.
- ☐ Ovarian cancer (including fallopian tube, serous intraepithelial carcinoma (STIC), and primary peritoneal)
- ☐ Male breast cancer at any age.
- ☐ Pancreatic adenocarcinoma at any age.
- ☐ Metastatic prostate cancer OR high risk prostate cancer at any age.
- ☐ Multiple cases of breast, ovarian, pancreatic and/or prostate cancer.

LYNCH SYNDROME (LS)-RELATED cancers*
- ☐ Colorectal OR endometrial cancer at age 50 or younger.
- ☐ Gastric OR gastroesophageal (GE) junction cancer at age 50 or younger.
- ☐ Immunohistochemistry (IHC) absent for MSH2, MSH6 or PMS2.
- ☐ IHC absent for MLH1 under age 70 and BRAF or MLH1 promoter hypermethylation normal/negative.
- ☐ Multiple primary LS-related cancers*, especially if one was diagnosed age 50 or younger.

*LS-related cancers include: colorectal, endometrial, gastric, GE junction, small bowel, pancreas, hepatobiliary, ovarian, ureter, renal pelvis, glioblastoma and sebaceous neoplasm (including keratoacanthoma).

COLORECTAL POLYPS
- ☐ Colorectal adenomas: 20 or more OR 10-19 age 60 or younger OR 5-9 before age 40 OR 5-9 with personal/family history of colorectal cancer, endometrial cancer, glioblastoma and/or astrocytoma.
- ☐ Colon/rectal serrated polyps: more than 20 OR 5 or more measuring 5 mm or larger.
- ☐ Hamartomatous polyps: 2 or more.

OTHER
- ☐ Breast, ovarian, pancreatic, prostate and/or colorectal cancer/polyps AND Ashkenazi Jewish ancestry.
- ☐ Renal tumour age 45 or younger OR bilateral/multifocal disease OR non-clear cell pathology OR with personal/family history of associated tumours (e.g. hemangioblastoma, leiomyomas, angiomyolipomas).
- ☐ Diffuse gastric cancer (DGC) and lobular breast cancer in the same person OR multiple cases in family members.
- ☐ Multiple gastrointestinal stromal tumours (GIST) in the same person OR in multiple family members.
- ☐ Pheochromocytoma OR paraganglioma.
- ☐ Sarcoma before age 45 and family history of young onset malignancy and/or evidence of syndromic presentation.
- ☐ 3 or more melanomas in the same person OR 3 or more relatives with melanoma and/or pancreatic cancer.
- ☐ Medullary thyroid cancer.

☐ Other personal or family history suggestive of hereditary cancer syndrome. Please describe cancer history:

_____

To inquire about a referral, call 416-480-6835. To inquire about a returned FHQ and/or appointment, call 416-480-5000 Ext. 85336

PR 47235
(2024/03/22)

FOR OFFICE USE ONLY: CLINIC:_____
HFN:_____ **DATE (YYYY/MM/DD):**_____ **TIME (h):**_____