Children's Hospital of Eastern Ontario
Centre hospitalier pour enfants de l'est de l'Ontario

401 Smyth Road
Ottawa, ON, K1H 8L1
Tel: 613-737-2275
Fax: 613-738-4822
www.cheo.on.ca

Please provide PATIENT INFORMATION including name, DOB, address, phone number and Health Card number

Patient email address:

HEREDITARY CANCER CLINIC REFERRAL FORM

REFERRING HEALTHCARE PROVIDER (please print or stamp):

Full Name:_____

Address: _____

_____

Physician number:_____

Phone #:_____Fax#:_____

URGENCY (please provide details):

□ Expedited Breast Cancer (see criteria on page 2):
If eligible by criteria 1, provide estimated start date of radiotherapy: _____
If eligible by criteria 2, provide estimated OR date:_____
NB: Testing will not be performed on an EXPEDITED basis if OR or RT scheduled to start < 8 weeks from day referral received.

□ Results will alter clinical management in near future (please provide details): _____

□ Palliative:_____

□ Clinical trial (specify): _____

□ Routine

PERSONAL HISTORY OF CANCER (please provide details regarding cancer type, age of diagnosis and provide pathology):

FAMILY HISTORY OF CANCER

Relative	Type of Cancer	Age at Diagnosis

CRITERIA FOR EXPEDITED BRCA1/2 TESTING (For Newly Diagnosed Breast Cancer)

The patient must meet the provincial guidelines for offering genetic testing and must meet criteria 1) or 2) below.

1. Patient is currently receiving treatment for breast cancer. Expedited testing would allow the patient the option of proceeding with prophylactic mastectomy, instead of radiation therapy, if she is found to carry a BRCA1/2 mutation. If mastectomy is chosen, the patient can avoid unnecessary radiation.

Please note: this criteria EXCLUDES elective reconstruction and/or prophylactic surgery as a reason for expedited testing, unless it is being done at the same time as surgery to treat the patient's cancer.

OR

2. Patient requires surgery for other urgent medical reasons (e.g. hysterectomy for uterine bleeding causing anemia) and may use the information to alter surgical decisions (e.g. salpingo-oophorectomy to be done with hysterectomy).

AND

Patient's surgery is to take place no sooner than 8 weeks from the date of blood draw.

CRITERIA FOR REFERRAL: INHERITED BREAST AND/OR OVARIAN CANCER

- ☐ Multiple cases of breast cancer (particularly where diagnosis occurred at less than 50 years) and/or ovarian* cancer (any age) in the family - especially in closely related relatives in more than one generation.
- ☐ Age at diagnosis of breast cancer less than 35 years.
- ☐ A family member diagnosed with both breast and ovarian* cancer.
- ☐ Breast and/or ovarian* cancer in Jewish families.
- ☐ Family member(s) with primary cancer occurring in both breasts - especially if one or both cancers were diagnosed before age 50.
- ☐ A family member diagnosed with invasive serous ovarian* cancer.
- ☐ Presence of male breast cancer in the family.
- ☐ Family member with an identified BRCA1 or BRCA2 mutation.
- ☐ Presence of other associated cancers or conditions suggestive of an inherited cancer syndrome.
- ☐ Other: _____

* includes cancer of the fallopian tubes and primary peritoneal cancer

CRITERIA FOR REFERRAL: INHERITED COLORECTAL CANCER

- ☐ Multiple cases in the family of the following cancers related to the hereditary non-polyposis colorectal cancer (HNPCC) spectrum, with at least one relative affected with colorectal or endometrial cancer. Age of onset less than 50 years, in closely related relatives and in more than one generation, would raise the index of suspicion.

  NOTE: *Cancers related to the HNPCC spectrum include: colorectal, endometrial, gastric, small bowel, hepatobiliary, pancreatic, ovarian, kidney, ureter, sebaceous carcinoma of the skin and brain cancers.*
- ☐ Age at diagnosis of colorectal cancer less than 35 years.
- ☐ Multiple primary cancers in one family member (see NOTE above for tumour sites).
- ☐ Family member with familial adenomatous polyposis (FAP), or 10 or more adenomatous polyps (suggestive of attenuated FAP).
- ☐ Family member with a colonic adenoma or cancer with high microsatellite instability (MSI).
- ☐ Family member with a known mutation causing either HNPCC or FAP.
- ☐ Other: _____

Referrals for other hereditary cancer syndromes not addressed by these guidelines can also be made to the CHEO Genetics Clinic.