

Your patient will be contacted within 10 days of receiving the referral. They will receive instructions on booking an appointment by telephone/email/text. If there are any changes to your patient's demographic information, please inform us as soon as possible at: genetics@dynacare.ca.

Your patient consents to receive communication by email. Referral Date (mm/dd/yyyy): _____

Patient information

Last Name: _____

First Name: _____

DOB (MM/DD/YYYY): _____

Health Coverage Information#: _____

Telephone# (Mobile preferred): _____

Address: _____

Email address: _____

Biological Sex at birth: ____ Gender Identity: _____

Physician/healthcare provider information

Name: _____

Telephone#: _____

Fax#: _____

Address: _____

Billing#: _____

Healthcare provider email address: _____

Healthcare provider signature: _____

Interpreter required: Yes No Language: _____

Reason for referral (Please check all that apply):

- Expedited/Urgent Referral:
 - Genetic test will alter surgical decisions
 - Planned Surgical Date: _____
 - Genetic test will impact treatment planning (i.e. PARP inhibitor)
 - Patient is Palliative (**Please Bank DNA immediately, if possible)
- Referred patient has/had cancer - Specify type(s) of cancer and age(s) at diagnosis (**please attach pathology report(s)): _____

- Family history of cancer Yes No
- Previous genetics assessment/genetic testing - Specify Name of Genetics Clinic: _____
- Gene/Mutation [please attach genetic test report(s)]
- Mutation/Assessment in a blood relative, [please attach genetic test report(s)]
Relationship to patient: _____
- Mutation/Assessment in patient : _____

Personal and/or family history of cancer (please check all that apply)

- Multiple primary cancers in one individual
- Breast**
 - Female Bilateral
 - Male Triple negative breast cancer
- Hematologic/Blood**
 - Lymphoma
 - Leukemia
 - Multiple myeloma

- Neurologic/Central Nervous System**
 - Glioblastoma Astrocytoma
 - Meningioma Ependymoma
 - Medulloblastoma Schwannoma
 - Optic nerve glioma Hemangioblastoma
 - Pituitary tumor Neuroblastoma
 - Atypical Teratoid/Rhabdoid tumor
 - Malignant Nerve Sheath Tumor

Personal and/or family history of cancer (please check all that apply)

Genitourinary

- Prostate cancer
 - Metastatic/castrate resistant/cribriform type/High risk
- Testicular cancer
- Bladder cancer
- Renal pelvis and Ureter cancer
- Urethral cancer
- Kidney cancer
 - Papillary Oncocytoma
 - Chromophobe Clear cell

Gastrointestinal

- Colon cancer
- Small bowel cancer
- Gastric Cancer:
 - Diffuse type Intestinal type
- Bile duct cancer
- Pancreatic adenocarcinoma
- Gastrointestinal stromal tumor(s)
- Colonic polyps:
 - >10 cumulative colorectal adenomas
 - ≥2 Peutz-Jeghers type hamartomatous polyps
 - ≥5 juvenile polyps
 - >20 serrated polyps
 - Other: _____

Skin

- Melanoma Uveal Melanoma
- Basal cell carcinoma Keratoacanthoma
- Sebaceous adenoma

Eye

- Retinoblastoma Uveal Melanoma

Respiratory/Thoracic

- Lung Cancer Thymoma
- Pleuropulmonary blastoma

Musculoskeletal

- Bone cancer Rhabdomyosarcoma
- Ewing sarcoma Osteosarcoma
- Soft tissue sarcoma

Endocrine and Neuroendocrine

- Adrenocortical carcinoma Pancreatic
- Parathyroid cancer Pheochromocytoma
- Gastrointestinal carcinoid Paraganglioma
- Thyroid cancer:
 - Papillary Follicular Medullary

Gynecological

- Uterine/Endometrial cancer
- Cervical cancer
- Ovarian, fallopian tube, peritoneal cancer

Other (Please specify): _____

Young onset cancer (Diagnosed < Age 50)

Please specify cancer(s) and age(s) at diagnosis in patient and/or family member(s):

Tumor testing (IHC deficient, MSI high, non-MMR IHC deficiency, Variants in tumor)

Tumor type: _____

Result (**Please provide copy of pathology/lab report): _____

Other indication

Please provide details:

Referral Checklist

The following must be provided with the referral

<input type="checkbox"/> Pathology report on patient's cancer diagnosis
<input type="checkbox"/> Pathology report on patient's colonoscopies
<input type="checkbox"/> Tumor/somatic testing report
<input type="checkbox"/> Genetic test results on patient and/or family member
<input type="checkbox"/> Genetics clinic consult letter and/or family tree