Dynacare®

Genetics and Specialty Services

Hereditary Cancer Referral Form

Your patient will be contacted within 10 business days of receiving the referral. They will receive instructions on booking an appointment by telephone/email. A family history questionnaire will be provided to the patient and must be completed prior to their appointment. 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): ____________

Their email address is ____________

Patient information

Last Name: ____________

First Name: ____________

DOB (MM/DD/YYYY): ____________

Health Coverage Information#: ____________

Telephone#: ____________

Address: ____________

Email address: ____________

Phone: ____________

Physician/healthcare provider information

Name: ____________

Telephone#: ____________

Fax#: ____________

Address: ____________

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: ____________

- ☐ Mutation/Assessment in a blood relative, 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

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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): ____________________

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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: ____________________

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Referral Checklist

The following must be provided with the referral

- ☐ Pathology report on patient's cancer diagnosis
- ☐ Pathology report on patient's colonoscopies
- ☐ Tumor/somatic testing report
- ☐ Genetic test results on patient and/or family member
- ☐ Genetics clinic consult letter and/or family tree