London Health Sciences Centre

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CANCER GENETICS REFERRAL FORM

Please fax completed referral form to: (519) 685-8005

DATE (DD/MM/YY): ____________________________

PATIENT NAME: ____

DOB (DD/MM/YY): ____________________________ HEALTH CARD#: ______________________________

ADDRESS: ____

CITY: ____ POSTAL CODE: ______________________________

TELEPHONE: (H)________________________ (W)____________________________ (ALT) ______________________

Does the patient currently have a diagnosis of cancer, or has she/he ever been diagnosed with cancer?

☐ YES ☐ NO ***If YES please send copies of all relevant cancer pathology reports along with referral***

Referrals *must* meet one of the following criteria (please check the box/boxes that apply)

☐ Family history of multiple (two or more) cases of cancer/tumours on the same side of the family, especially in close relatives over more than one generation, including:

- ☐ cancers/tumours diagnosed at younger ages than expected (e.g. less than age 50)
- ☐ multiple primary tumours in one individual
- ☐ pattern of cancer/tumours suggestive of a known hereditary cancer syndrome (i.e. breast/ovarian/prostate/pancreatic, or colon/uterine/stomach/ovarian)

☐ Family history or personal history of breast cancer <35 years old

☐ Family history or personal history of ovarian cancer, diagnosed at any age

☐ Breast and/or ovarian cancer in Ashkenazi Jewish families

☐ Family history or personal history of male breast cancer

☐ Family member with a known inherited hereditary cancer gene mutation (e.g. *BRCA1/2, MLH1/MSH2/MSH6, APC*), please specify:______________________________________

Details of personal or family history of cancer if known: (i.e. type of cancer, who in the family is affected, age of diagnosis): ______________________________________

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Interpreter required: ☐ YES ☐ NO If yes, language: ______________________________

REFERRING PHYSICIAN ____

ADDRESS ____

____

PHONE NUMBER (______)____

FAX NUMBER (______)____