Cancer Program
WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

CANCER GENETICS
REFERRAL FORM

erie st. clair regional cancer program
in partnership with cancer care ontario

Patient Details		Physician Details	
Patient Name:	**DOB (d/m/y):**	**Referring Physician:**	
Address:	**City:**	**Telephone:**	**Fax:**
Postal Code:	**Sex:** ❑ Male ❑ Female	**Physician Health Number:**	
Home: **Work:**	**Cell:** **Other:**	**Family Physician/Nurse Practitioner:**	
HCN & VC:			

REASON FOR REFERRAL:

REFERRAL MUST MEET ONE OF THE FOLLOWING CRITERIA:

MULTIPLE: A combination of cancers on the same side of the family or in the same person *(particularly if diagnosed less than age 50)*

- □ **2 or more:** breast / ovarian / prostate / pancreatic / melanoma
- □ **2 or more:** colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter, transitional cell kidney, biliary tract, small bowel, keratoacanthoma, sebaceous adenoma)

YOUNG: Cancer diagnosed at age **35 or younger**

- □ Specify cancer diagnosis: _____

RARE: Any 1 of these rare presentations at **any age**

Relevant pathology MUST accompany all of the following indications:

- □ Invasive serous ovarian*
- □ Male breast cancer
- □ Triple negative breast cancer* diagnosed less than age 50
- □ Colorectal cancer with abnormal MSI/IHC††
- □ 10 or more adenomatous GI polyps
- □ Other rare presentation suggestive of hereditary cancer
  - □ Specify: _____
- □ A known hereditary cancer gene mutation in the family (i.e.: *BRCA1/BRCA2/MLH1/MSH2/RET/APC* etc.)
  - □ Specify gene:_____ Relative: _____

**includes cancer of the fallopian tube(s) and primary peritoneal cancer*
††MSI (microsatellite instability) and/or IHC (immunohistochemistry shows absent MLH1/MSH2/MSH6/PMS2)

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

❑ YES* ❑ NO

**If YES please send copies of all relevant cancer pathology reports along with referral*

Details of personal and/or family history of cancer:

(i.e.: type of cancer, who in family has cancer, and their age at diagnosis, etc.)

_____
_____
_____
_____
_____
_____
_____

Interpreter required: ❑ YES ❑ NO
If yes, language: _____

Your patient will be contacted within 2 business day of receiving the referral and provided further instructions, which includes the completion of a family history questionnaire – **this must be completed and returned prior to booking an appointment.**

Genetic testing may or may not be offered in the course of a genetics consultation, pending eligibility.

Referral criteria is based on most recent Ministry of Health of Ontario guidelines and are subject to change. If uncertain about the appropriateness of a referral or feel your patient would benefit from counselling but does not meet the guidelines, please contact the genetic counsellor at **519-254-5577 ext: 58601**

Physician Signature:

_____

Date: _____

Fax completed forms to: 519-255-8688