Shared health Soins communs Manitoba

Program of Genetics & Metabolism
HSC Winnipeg
FE229 820 Sherbrook Street
Winnipeg, MB R3A 1R9
P: (204) 787-2494
F: (204) 787-1419

HEREDITARY CANCER CLINIC REFERRAL FORM

Please fax completed form(s) to: (204) 787-1419

Patient's Name	Legal Name (if different)		Sex Assigned at Birth
DOB (dd/mmm/yyyy)	PHIN#	Gender	Pronouns
Address (Street, City, Postal Code)	Daytime phone #:	Home phone#:	
	Email:		
Is Maternal Ethnicity any of the following? (circle all the apply) Ashkenazi Jewish / Mennonite / Icelandic or First Nations	Is Paternal Ethnicity any of the following? (circle all the apply) Ashkenazi Jewish / Mennonite / Icelandic or First Nations		
Referring Physician	Address (Street, City, Postal Code)	Phone #:	
		Fax #"	
Interpreter or ASL required: N / Y	Specify Language:		

1. **Does this individual have a PERSONAL history of cancer?** ☐ NO ☐ YES
   a) Cancer type(s): _____ if available, please include pathology report.
   b) Age(s) at diagnosis: _____
   c) Genetic assessment affects immediate treatment decisions (surgery or medication)? ☐ NO ☐ YES
2. **Does this individual have a PERSONAL history suggestive of a polyposis syndrome or other hereditary cancer syndrome*?** ☐ NO ☐ YES
   Please specify: _____ Please provide all relevant reports
3. **Is there a known hereditary cancer condition in a blood relative?** ☐ NO ☐ YES

Hereditary Condition / Gene	
Name of blood relative	
Relationship to your patient	
City/clinic where tested	

Additional details:
_____
_____
_____

If available, please enclose any molecular reports.

4. **Does this individual have a FAMILY history that is suggestive of a hereditary cancer syndrome*?** ☐ NO ☐ YES Please specify: _____
   _____
5. **Please have patient complete the FAMILY History Questionnaire.** ☐ ENCLOSED ☐ PENDING
6. **Is this patient or their family member with cancer palliative or terminal?**
   ☐ NO ☐ YES Please specify: _____

***Suggested resource:**
https://www.acmg.net/docs/ACMG_Practice_Guideline_Referral_Indications_for_cancer_predisposition.pdf
Please note that we do not have the capacity to see all patients who meet these referral criteria.

Shared health Soins communs Manitoba

Program of Genetics & Metabolism
HSC Winnipeg
FE229 820 Sherbrook Street
Winnipeg, MB R3A 1R9
P: (204) 787-2494
F: (204) 787-1419

HEREDITARY CANCER CLINIC FAMILY HISTORY FORM

Name: _____ Legal Name (if different): _____

Sex assigned at birth: male / female / unassigned Gender: _____ Pronouns (he/she/they): _____

Referring Physician: _____ PHIN: _____

Birthdate: _____ Daytime Phone #(s): _____
month / day / year

The information you provide will help us assess the chance of a hereditary type of cancer (cancer that "runs in the family") and your risk for cancer. The information is kept confidential.

Tips for completing this questionnaire:

- We are asking about your biological relatives, meaning relatives related to you by blood. This may include information about an egg/sperm donor or half-siblings, but not in-laws or step siblings.
- Please provide as much information as you can. You may find it useful to contact other family members for help. Ages and years of diagnosis/death can be approximated.
- If you need more space for any section, or if you wish to provide any other information that you feel is important, please attach additional pages.
- When listing the name of a family member, please include the last name and maiden name (in brackets).
- Please indicate anyone whose sex assigned at birth is different from their gender identity.
- Please print clearly.

Please return this form to: Hereditary Cancer Clinic **OR** Fax it to (204)787-1419
Genetics and Metabolism Program
FE229- CSB - Health Science Centre
685 William Ave, Winnipeg, MB R3E 0Z2
(prepaid preaddress enveloped enclosed)

If you have any questions, please contact the Hereditary Cancer Clinic at 204-787-4267

Section 1: Yourself

Have you ever had any non-cancerous lumps, polyps, moles? YES / NO If YES → Please complete table below

Site or Type of Non-Cancerous Change	Age when found

Have you ever been diagnosed with cancer? Yes / No If yes, please provide the details for each cancer diagnosis **you** have had.

Type of cancer	Age at diagnosis	Hospital and city where treated

Please complete next section only if it applies to you:

1. How old were you when you had your first period? ___years

2. Have you ever had a baby? YES / NO

   If YES: How old were you when you had your first baby? _____ years

   If NO: Have you ever been pregnant? YES / NO

3. Have you started change of life (menopause)? YES / NO

   If YES: How old were you when it started? _____ years

4. Do you still have your uterus (womb) or ovaries ? YES / NO

   If NO: How old were you when your uterus or ovaries were removed? _____ years

5. Have you ever had a doctor examine a lump or mass in your breast(s)? YES / NO

   If YES: (a) Has a doctor ever removed a lump or examined it with a needle (biopsy)? YES / NO

   (b) Have you had more than one lump removal / biopsy? _____ number

   (c) Did your doctor ever tell you that there were atypical cells? YES / NO

Name: _____ PHIN: _____

Section 2: Background information

1. Were you adopted? Yes / No
   If yes, please complete this questionnaire to the best of your ability for blood (biological) relatives only.

2. Has anyone in your family had genetic counselling or genetic testing for the family history of cancer? Yes / No

   Name of family member(s) and relationship to you: _____

   Where were they seen: _____
   Genetics Clinic City Province

   ***If available and where appropriate, when returning this form please include a copy of the DNA reports for your relatives.

Section 3: Your biological family

Do you have children? Yes or No If yes, how many boys_____ and how many girls_____? What is their age range? _____

Do you have any full siblings? Yes or No If yes, how many brothers _____and how many sisters_____? What is their age range? _____

Do you have any half siblings? Yes or No If yes how many brothers _____ and how many sisters_____ with the same mom as you?

If yes how many brothers _____ and how many sisters_____ with the same dad as you?

Your	Name	Current age (if alive)	If deceased, age and cause of death	# of their siblings	
				male	female
Mother					
Father					

What is your family's ethnic/ancestral background? Please be specific. (e.g. Inuit, French, Polish, Ukrainian, German, Irish, Pakistani, Filipino, Italian, Chines, etc.)

Mother side: _____ Father side: _____
(Ashkenazi Jewish / First Nations / Icelandic / Mennonite) (Ashkenazi Jewish / First Nations / Icelandic / Mennonite)

Note: Some inherited cancer conditions maybe more common in the ethnic groups listed in brackets above please circle any or all that apply.

Name: _____ PHIN: _____

Section 4: Family members with cancer

Please list **all biological family members (living or deceased) affected with cancer**, even if they have been listed in previous sections.

When listing the **type of cancer**:

- Please indicate where the cancer started. e.g. breast cancer that spread to the lung should be identified as breast cancer.
- If the cancer is gynecologic, please state if it was in ovary, uterus, or cervix. If unsure, put gynecologic cancer.
- If cancer was in the abdomen but the site is unknown, please put abdomen.

Name	**Relationship to you (include side of the family)**	**Type of cancer**	**Age at diagnosis**	**Year diagnosed**	**Hospital and/or city where treated**	**Living (Y / N)**
e.g. John Smith	*cousin (mother's brother's son)*	*colon*	*early 40's*	*~ 2000*	*Cross Cancer, Edmonton*	*Y*

Thank you for taking the time to complete this questionnaire!

Name: _____ PHIN: _____