Cancer Centre of Southeastern Ontario
A Cancer Care Ontario Partner
Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Queen's University

DIVISION OF MEDICAL GENETICS
FAMILIAL ONCOLOGY PROGRAM
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FAMILIAL ONCOLOGY PROGRAM - REFERRAL FORM

REFERRING PHYSICIAN INFORMATION	PATIENT DEMOGRAPHICS
Name_____	Name_____
Phone _____	DOB _____
Fax _____	Phone _____
Signature _____	MOH _____
Date _____	Address _____
	Email _____

Please select the applicable criteria and include pathology and family history with referral

Mainstreaming (Oncologists only) ❑ Bloodwork done	❑ Invasive epithelial ovarian cancer and/or epithelial fallopian tube (including STIC and STIL) or peritoneal cancers. Borderline/low malignant potential tumors excluded. ❑ Pancreatic adenocarcinoma, any age ❑ Metastatic or high risk, locally advanced prostate cancer, any age
Hereditary Breast and Ovarian Cancer ❑ Expedited for surgery	❑ Breast ≤45 ❑ Breast ≤50 with limited family structure or second primary breast cancer ❑ Triple negative invasive breast cancer ≤60 ❑ Male breast cancer ❑ Breast cancer + family history of breast cancer ≤50, triple negative breast cancer ≤60, ovarian cancer, male breast cancer, high risk prostate cancer, pancreatic cancer, ≥2 additional breast/prostate cancer cases
Assessment for High Risk Ontario Breast Screening Program	❑ Unaffected female between ages 30-69 AND family history of breast/ovarian cancer (signed OBSP Requisition for High Risk Screening must be included with referral)
Lynch Syndrome	❑ Colorectal or uterine cancer ≤ 50 regardless of IHC results ❑ MSH2 / MSH6 deficient tumor ❑ MLH1 / PMS2 deficient tumor AND BRAF V600E negative AND MLH1 promoter methylation is normal (all investigations must be completed)
Polyposis	❑ ≥20 colorectal adenomas, any age ❑ 10-19 colorectal adenomas < 60 years ❑ 5-9 colorectal adenomas and family history of polyps/colorectal/endometrial cancer ❑ Fundic Gland Polyposis (FGP) or Hamartomatous Polyposis
Familial Variant Testing	Relative's name: _____ Relationship to patient: _____ ❑ Genetic test result/ family letter attached (must be included with referral)
Re-analysis	❑ VUS reinterpretation (copy of previous test result must be included with referral) ❑ Updated testing (copy of previous test result must be included with referral)
Other Reason* (please specify)	

* Please refer to Cancer Care Ontario: Hereditary Cancer Testing Eligibility Criteria: Version 3 for other indications where genetic testing may be indicated