Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Health Sciences Centre Winnipeg

HEREDITARY BREAST CANCER CLINIC REFERRAL

Genetics, FE229 – CSB, Health Science Centre, 820 Sherbrook St. Winnipeg, MB R3A 1R9
Phone: (204)787-8860 FAX: (204)787-1419

Patient's Surname	Given Name	Middle Initial	Sex (M/F)

Patient's MHSC#	Patient's PHIN#	CR#	DOB (d/m/y)

Address (Street, City, Postal Code)	Home phone #
	Work phone #/Daytime phone #

Referring Physician	Address (Street, City, Postal Code)	Phone #
		Fax #
Family Physician	Address (Street, City, Postal Code)	Phone #
		Fax #

Please provide as much detail as possible in indicating which of the following criteria apply to this referral.

Personal history (patient or close relative):

- □ breast cancer diagnosed at age 35 or younger - age at diagnosis: _____
- □ ovarian cancer diagnosed at age 50 or younger - age at diagnosis: _____
- □ an Ashkenazi Jewish or Icelandic women with breast or ovarian cancer diagnosed at any age
- □ bilateral breast cancer where both diagnoses were made prior to age 50
- □ a blood relative with a confirmed mutation of a breast cancer susceptibility gene (ie BRCA1 or BRCA2)

Family history includes the following:

- □ 2 or more closely related family members (parents, siblings, children, grandparents, aunts and uncles) on the same side of family, where the diagnoses of breast cancer was made before the age of 50
- □ multiple primary cancers in 1 individual - please specify: _____
- □ 3 or more individuals in a first-degree relationship with the following tumors: breast, ovary, pancreas, fallopian tube and peritoneal cancer with at least one diagnosis under the age of 50
- □ male breast cancer

If this person should be seen urgently (eg patient or family member with cancer is dying), **please explain:** _____

_____

_____

Family History Form – completed by the patient & ☐ attached or ☐ to be forwarded separately.

Please MAIL the completed form(s) to the above address, or FAX to (204) 787-1419