Health Sciences Centre
Winnipeg

WRHA Program of Genetics & Metabolism

FE229 – Community Services Building
Health Sciences Centre 820 Sherbrook Street
Winnipeg, MB R3A 1R9
Phone #: 204-787-4267

HEREDITARY CANCER CLINIC REFERRAL FORM

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

DATE (DD/MM/YY): _____

PATIENT NAME: (in full)_____

DOB (DD/MM/YY): _____ MHSC / PHIN #: _____

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?

☐ NO ☐ YES please specify type of cancer and age of diagnosis: _____

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

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

☐ Family history of 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 or colon cancer <35 years old

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

☐ Breast and/or ovarian cancer in Ashkenazi Jewish / Icelandic families

☐ Family history or personal history of male breast cancer

☐ Patient with colonic tumour with abnormal immunohistochemistry

☐ Family member with a known inherited hereditary cancer gene mutation (e.g. *BRCA1/2, MLH1/MSH2/MSH6, APC, CDH1*), please specify:_____

☐ Family or personal history of other types of cancers, 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): _____

_____

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

REFERRING PHYSICIAN _____

ADDRESS _____

_____

PHONE NUMBER (_____)_____

FAX NUMBER (_____)_____

Questions regarding referring patients to the Hereditary Cancer Clinic, please call 204-787-4267