

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) <input type="checkbox"/> Bloodwork done	<input type="checkbox"/> Invasive epithelial ovarian cancer and/or epithelial fallopian tube (including STIC and STIL) or peritoneal cancers. Borderline/low malignant potential tumors excluded. <input type="checkbox"/> Pancreatic adenocarcinoma, any age <input type="checkbox"/> Metastatic or high risk, locally advanced prostate cancer, any age
Hereditary Breast and Ovarian Cancer <input type="checkbox"/> Expedited for surgery	<input type="checkbox"/> Breast ≤45 <input type="checkbox"/> Breast ≤50 with limited family structure or second primary breast cancer <input type="checkbox"/> Triple negative invasive breast cancer ≤60 <input type="checkbox"/> Male breast cancer <input type="checkbox"/> 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	<input type="checkbox"/> 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	<input type="checkbox"/> Colorectal or uterine cancer ≤ 50 regardless of IHC results <input type="checkbox"/> MSH2 / MSH6 deficient tumor <input type="checkbox"/> MLH1 / PMS2 deficient tumor AND BRAF V600E negative AND MLH1 promoter methylation is normal (all investigations must be completed)
Polyposis	<input type="checkbox"/> ≥20 colorectal adenomas, any age <input type="checkbox"/> 10-19 colorectal adenomas < 60 years <input type="checkbox"/> 5-9 colorectal adenomas and family history of polyps/colorectal/endometrial cancer <input type="checkbox"/> Fundic Gland Polyposis (FGP) or Hamartomatous Polyposis
Familial Variant Testing	Relative's name: _____ Relationship to patient: _____ <input type="checkbox"/> Genetic test result/ family letter attached (must be included with referral)
Re-analysis	<input type="checkbox"/> VUS reinterpretation (copy of previous test result must be included with referral) <input type="checkbox"/> 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