



**Lakeridge
Health**

Genetics Clinic Referral

Phone: 905 433 2733 Fax: 905 721 6122

****Incomplete or illegible forms will be declined****

****Please include all relevant medical records to allow efficient booking****

PATIENT DEMOGRAPHICS

Name: _____ M F

DOB dd/mm/yy: _____

OHIP#: _____ VC: _____

Address: _____

Home Phone: _____

Alternate Phone: _____

For minor patients, please provide name of
parent(s)/legal guardian(s): _____

PRENATAL REFERRAL (MUST INCLUDE LMP/DATING ULTRASOUND)

(Please attach antenatal records, ultrasound
reports, prenatal lab results, screening reports)

LMP: DD/MM/YY: _____

- Late maternal age/Prenatal screening
- Positive prenatal screen
- Fetal ultrasound anomalies
- Family history of genetic condition or birth defect

GENERAL REFERRAL

(Please provide details on the right and attach
all relevant records/consult notes)

- Is this patient clinically affected? no yes
- Pediatric assessment
- Assessment for adult onset disorders
- Genetic counselling: family history of genetic conditions or birth defects

HEREDITARY CANCER REFERRAL

(see page 2 for referral criteria)

Does the patient have a personal history of
cancer? no yes (please attach pathology)

Type _____

Age at Diagnosis: _____

Has a mutation been identified in the family?

no yes

Which gene? _____

REFERRING PHYSICIAN

Doctor's name: _____

Address _____

Telephone #: _____

Fax #: _____

Physician billing #: _____

Signature: _____

If this referral is URGENT, please specify why

Please provide additional details/relevant
family history regarding this referral:

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LAKERIDGE HEALTH CLINICAL GENETICS: HEREDITARY CANCER REFERRAL CRITERIA

Please check all that apply

HEREDITARY BREAST AND OVARIAN CANCER (HBOC):

- Multiple cases of breast cancer in family (3 or more cases at any age or 2 under 50 years of age)
- Breast cancer diagnosed under 35 years of age
- Triple negative breast cancer diagnosed under 60 years of age
- Bilateral breast cancer
- Breast and ovarian cancer within the same family
- Breast/Ovarian cancer in Ashkenazi Jewish women
- Male breast cancer
- Personal/family history of ovarian cancer
- Other HBOC associated cancers in family: melanoma, pancreatic or prostate cancer diagnosed at a young age
- Known BRCA1/2 mutation in the family
- Anyone who had BRCA1/2 genetic testing prior to April 1, 2008

Please note: additional testing may be available to patients who have previously had negative BRCA1/2 genetic testing and have a strong family history (4 or more cases) of breast/ovarian/other cancers.

- OBSP High-Risk Breast Screening Assessment

HEREDITARY COLORECTAL CANCER: (Lynch syndrome, Polyposis):

- Individual with colon or uterine cancer diagnosed under 60 years old
- Individual with 10 or more colorectal polyps
- Multiple cases of colorectal cancer in the family
- Family history suggestive of Lynch Syndrome (colorectal, endometrial, pancreatic, ovarian, kidney, urinary tract, small bowel, gastric and brain cancers)
- Family history suggestive of hereditary polyposis
- Known Lynch (MLH1, MSH2, MSH6, PMS2, EPCAM) or polyposis (APC, MutYH) gene mutation in family

OTHER HEREDITARY CANCERS: (Exclusions: lung and cervical cancer)

- A family history of a known hereditary cancer syndrome. Please provide details on page 1.
- Individual diagnosed with more than one primary cancer
- Multiple family members with the same cancer or rare cancers, especially if diagnosed under age 50

Please note: If you are uncertain whether an individual/ family history will meet criteria, please refer. We will triage the referral and notify your office of the decision regarding eligibility. We suggest informing your patient that their family history will be evaluated to determine if there is a need for an appointment. Genetic testing is offered only to families that are suggestive of a hereditary cancer syndrome, and in most cases will be offered to a family member affected with cancer first.

Updated June 2016