Thunder Bay Regional Health Sciences Centre

CLINICAL GENETICS PROGRAM

REFERRAL FORM (CANCER)

Patient Name: _____

D.O.B. (YYYY-MM-DD): _____

Address: _____

City/Town, Prov:_____

Postal Code: _____Tel: _____

Health Card #: _____Version: ____

Place Patient Label with Barcode Here

Guidelines for Completion:

1. We accept cancer referrals for patients who meet the criteria outlined in the provincial Referral Guidance for Hereditary Cancer Genetic Assessment (available at www.tbrhsc.net/genetics).
2. Complete all fields and fax to 807-684-5823. **INCOMPLETE OR ILLEGIBLE FORMS MAY BE RETURNED.**
3. Please include pathology reports with referral, if applicable.
4. If referring for a family history of breast and/or ovarian cancer and the patient has not had cancer, please complete a High Risk OBSP Requisition (available at www.tbrhsc.net/genetics) and fax to 807-684-5810.

Sex assigned at birth: _____ Gender: _____ Pronouns: _____/_____/_____

Are interpretation services required? ☐ Yes ☐ No If yes, for which language? _____

Has the patient been diagnosed with cancer? ☐ Yes ☐ No

If yes, describe type(s) of cancer and age(s) of diagnosis:_____

_____

Does the patient meet at least one criterion on the Referral Guidance for Hereditary Cancer Genetic Assessment?

☐ Yes ☐ No (If no please explain why the patient needs an appointment):

_____

_____

Is this an urgent referral? ☐ Yes ☐ No (Urgent referrals will be prioritized)

If yes, please check one of the following: ☐ Genetic results will impact immediate medical treatment

☐ Patient is palliative

Does the patient have a blood relative with a confirmed pathogenic or likely pathogenic variant in a cancer susceptibility gene? ☐ Yes ☐ No **If yes**, please attach a copy of the genetic testing report or family letter (required).

FAMILY HISTORY

(Please list family members that have been diagnosed with cancer)

Relationship to patient and side of family (e.g. maternal aunt)	Type of Cancer	Age at diagnosis

Referring Health Care Provider Information:

Name: _____ Signature: _____ Referral Date: _____

Address/Clinic/Facility: _____

Telephone #: _____ Fax # (to send correspondence/results): _____

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