IWK Health

5850/5890 University Ave
PO BOX 9700
Halifax, NS B3K 6R8
(T) 902-470-8754
(F) 902-470-8709

Maritime Medical Genetics Service
Hereditary Cancer Referral

Referral Date (DD/MM/YY): _____

Referring Clinician:			(T)	(F)
Family Care Provider:			(T)	(F)
Patient	Last Name	First Name	DOB	Health Card
	Address:			
	City/Town	Province	Postal Code	Phone Numbers
				(1)
	Gender:	Pronouns:		(2)
	Is an Interpreter required: ☐ No ☐ Yes		Preferred/Primary Language:	

PLEASE INCLUDE A RECENT CONSULT NOTE AND RELEVANT PATHOLOGY.
FAILURE TO INCLUDE WILL DELAY PROCESSING OF YOUR REFERRAL.

Referrals are only expedited if results will have IMMEDIATE impact to care (or patient survival is < 6 months).
Please explain HOW results will alter care and provide timeline:

Please note that results take at least 6 weeks from time of referral. If insufficient information is provided, referrals will be processed based on our standard process. Any clinician can organize DNA banking for ill patients.

Reason for referral – *Select 1 or more of the following:*

Personal History – Please attach relevant pathology and consults

Age Specific Diagnosis:
- ☐ Breast cancer, diagnosed < age 40
- ☐ Two primary breast cancers, with at least one diagnosed < age 50
- ☐ Triple negative breast cancer, diagnosed < age 60
- ☐ Colon cancer, diagnosed < age 40
- ☐ Endometrial cancer, diagnosed < age 40
- ☐ Prostate cancer, diagnosed < age 50
- ☐ Unilateral renal cancer, diagnosed under age 50
- ☐ Bilateral renal cancer, diagnosed under age 70

At any age:
- ☐ Ovarian, fallopian tube or peritoneal cancer (incl. STIC lesions)
- ☐ Male breast cancer
- ☐ Metastatic prostate cancer
- ☐ Pancreatic adenocarcinoma
- ☐ dMMR Lynch syndrome related cancer (IHC deficient)
- ☐ Polyposis (≥10 adenomas **or** ≥2 hamartomas **or** meets sessile serrated guidelines)
- ☐ 3 or more malignant melanoma
- ☐ Medullary thyroid cancer
- ☐ Paraganglioma/pheochromocytoma

Family history of a confirmed hereditary cancer condition – Please attach any letters or records provided

Relative's Name	Date of Birth	Relationship (parent, sibling)	Gene	Clinic/City

Family history – Questionnaire will be mailed to your patient; outcome of assessment will be relayed via letter or appointment

- ☐ Close relative meets above criteria
- ☐ Other:

Other – Please specify