Northeastern Ontario Medical Genetics Program
Sudbury Outpatient Centre, Health Sciences North
865 Regent Street South – Sudbury, ON P3E 3Y9
Tel: (705) 675-4786 | Fax: (705) 523-7178
www.hsnsudbury.ca/genetics

ADDRESSOGRAPH

REQUEST FOR CANCER GENETICS CONSULTATION

PLEASE PRINT CLEARLY. FORWARD THE COMPLETED FORM TO THE NORTHEASTERN ONTARIO MEDICAL GENETICS PROGRAM VIA FAX.

PATIENT DEMOGRAPHIC INFORMATION Date of Birth: YYYY / MM / DD OHIP#: ___________________________

Last Name: _______________________________ First Name: ______________________ Other/Preferred: __________________

Sex Assigned at Birth: □ Male □ Female □ Unknown/Specify: ________________________ Gender Identity: __________________

Address: ____ Pronouns: _______________________

City: _____________________________________ Postal Code: _____________________ Email: ___________________________

Telephone (Preferred): ______________________ Telephone (□ Alternative / □ Contact Person): ______________________________

Contact person name/relationship to patient (if applicable): ____

Preferred Language: □ English □ French □ Other (specify): __________________________ Patient aware of referral? □ Yes □ No

THE MEDICAL INFORMATION BELOW IS REQUIRED IN ORDER FOR US TO PROCESS THE REFERRAL. Please complete all sections, and attach all requested relevant medical documentation with your referral (i.e. pathology reports, genetic test reports, etc.).

1) **IS THIS REFERRAL URGENT (I.E. RESULTS OF ASSESSMENT WILL ALTER IMMEDIATE CLINICAL MANAGEMENT)? □ YES □ NO**
IF YES, SPECIFY THE FOLLOWING (REQUIRED): DATE GENETIC TEST RESULTS REQUIRED BY: ________________________________
REASON(S): □ SURGICAL/ONCOLOGIC TREATMENT PLANNING - ANTICIPATED TREATMENT DATE: _________________________
□ PALLIATIVE (I.E. END OF LIFE) □ OTHER (SPECIFY): ____

2) **IS THIS REFERRAL RELATED TO MAINSTREAMING (I.E. GENETIC TESTING ALREADY ORDERED BY AN ONCOLOGIST)? □ YES □ NO**
IF YES, HAVE GENETIC TEST RESULTS BEEN RECEIVED? □ YES, GENETIC TEST REPORT INCLUDED (REQUIRED) □ NO

3) **DOES THIS PATIENT HAVE A PERSONAL HISTORY OF CANCER? □ YES □ NO**
IF YES, COMPLETE THE TABLE BELOW AND INCLUDE ALL RELEVANT PATHOLOGY REPORTS (REQUIRED).
Notes: Referrals for a personal history of colon polyps must also include all relevant pathology reports. If no pathology report is available for your patient, please provide other relevant medical documentation as confirmation of diagnosis (e.g. consultation letter).

CANCER TYPE(S)	AGE(S) AT DIAGNOSIS

4) **DOES THIS PATIENT HAVE A FAMILY HISTORY OF CANCER? □ YES □ NO**
IF YES, COMPLETE THE TABLE BELOW AND INCLUDE ALL KNOWN DETAILS (REQUIRED).

RELATIONSHIP TO THIS PATIENT (i.e. sibling, parent, aunt/uncle, grandparent)	SIDE OF FAMILY (i.e. maternal/paternal)	CANCER TYPE(S)	AGE(S) AT DIAGNOSIS	ALIVE?
				□ YES □ NO
				□ YES □ NO
				□ YES □ NO
				□ YES □ NO
				□ YES □ NO
				□ YES □ NO

5) **IS THIS PATIENT IS ADOPTED? □ YES □ NO IF YES, IS BIOLOGICAL FAMILY HISTORY INFORMATION AVAILABLE? □ YES □ NO**

6) **HAS A CLINICALLY SIGNIFICANT VARIANT BEEN IDENTIFIED IN □ THIS PATIENT AND/OR □ THEIR RELATIVE(S)?**
IF YES, INCLUDE A COPY OF THE GENETIC TEST REPORT(S) (REQUIRED) AND SPECIFY RELATIONSHIP TO THIS PATIENT: ____________________

7) **IS THERE ANY RELEVANT INFORMATION REGARDING ANY ACCOMODATION THAT CAN BE MADE TO BETTER SERVE THIS PATIENT (I.E. DISABILITY, HEARING/VISION LOSS, SOCIAL SITUATION, INCREASED RISK FOR FALLS, ETC.)?** ____________________________
____

REFERRING HEALTH CARE PROVIDER*: Provider #: ________________________________
Name: _________________________ Address: ____________________________________
Telephone: _____________________ ____________________________________
Fax: ___________________________ Signature: ___________________________________

REFERRAL CHECKLIST:
- □ Completed Genetics Requisition Form
- □ Pathology report(s), imaging report(s) and/or consultation note(s), if applicable
- □ Genetic test report(s), if applicable

** Please ensure all demographic information is completed in full, including the full name of the referring health care provider, as well as the fax number, in order to ensure that our communication reaches you. We will respond to all referral requests and confirm our triage decision via fax within two weeks.*

WHO SHOULD BE REFERRED TO A GENETICS CLINIC FOR ASSESSMENT?

- Individuals who are suspected to be at an increased risk for an inherited cancer syndrome can be referred to a Genetics Clinic for evaluation. All referrals are reviewed and triaged by our medical team.
- Referrals may be made for individuals who have been diagnosed with cancer, as well as unaffected individuals with a family history of cancer, if they meet the referral criteria outlined below. Additional information about Referral Guidance for a Hereditary Cancer Genetics Assessment can be found here: https://www.ontariohealth.ca/sites/ontariohealth/files/2023-04/CancerGeneticAssessmentReferralGuidance.pdf
    - Please note that genetic testing may or may not be offered as part of a Genetics consultation.

REFERRAL CRITERIA

- We accept referrals for all patients who have been diagnosed with cancer and meet the Ontario Health – Cancer Care Ontario (OH – CCO) Hereditary Cancer Testing Eligibility Criteria, which can be found here: https://www.cancercareontario.ca/en/guidelines-advice/types-of-cancer/70161
- For patients who have not been diagnosed with cancer, we will consider accepting a referral if they meet one or more of the following criteria:
    - The patient meets criteria for an assessment for the Ontario Breast Screening Program High Risk Screening Program (OBSP – HRS Program), as listed in Category B of the OBSP – HRS Program Requisition form, which can be found here:
      https://www.cancercareontario.ca/sites/ccocancercare/files/assets/OBSPHighRiskForm.pdf
    - Your patient has a relative who has been found to carry a clinically significant variant in a gene known to be associated with a hereditary cancer syndrome.
        - Note: if submitting a referral for this indication, a copy of the relative's genetic test report (i.e. from the genetic testing laboratory) must be submitted with the referral. Otherwise, the request for consultation will be declined due to lack of supporting medical documentation.
- If a patient has not been diagnosed with cancer and has at least one living relative who meets the OH – CCO Hereditary Cancer Testing Eligibility Criteria, our recommendation is that the patient's relative(s) be referred to a Genetics Clinic for assessment. Consideration of genetic testing for unaffected individuals will be given in the event that the family history of cancer is suggestive of a hereditary cancer syndrome, and no living relative(s) is/are available for testing. These referrals will be reviewed by our medical team, and published empirical evidence and/or established risk models will be used to determine eligibility for genetic testing.

URGENT REFERRAL REQUESTS AND EXPEDITED TESTING CRITERIA

- Urgent consultation requests will be reviewed promptly by our medical team, and triaged according to our departmental protocol, based on the information provided with the referral. Please indicate clearly the reason for which an urgent consultation is being requested for your patient on the referral form.
- Referrals may be triaged as urgent, if the patient meets one or more of the following criteria:
    - Diagnosed with cancer and palliative (i.e. at end of life);
    - Eligible for expedited* genetic testing, as per the OH – CCO Hereditary Cancer Testing Eligibility Criteria;
      ** Expedited genetic testing is indicated for eligible individuals for whom the results of germline testing could impact surgical and/or oncological treatment planning that is scheduled within the next four to eight weeks, including patients for whom Olaparib is being considered as a treatment option.*
    - The referring health care provider provides another reason to triage the referral as urgent, which has been approved by our medical team.

CONTACT US

- If you have any questions about the above information, or if you have questions regarding the appropriateness of a referral, please contact us at (705) 675-4786.