

**Kingston Health
Sciences Centre**

Centre des sciences de
la santé de Kingston



Hôpital
Hôtel Dieu
Hospital



Hôpital Général de
Kingston
General
Hospital

Internal Lab use only

CR# or Hospital ID #: _____

Patient Name: _____
(Last) (First)

Date of Birth (YYYY/MM/DD): ____/____/____ Sex: M/F

Health Card #: _____ Expiry Date: _____

Address: _____

Postal Code: _____ Phone: _____

**Molecular Genetics Laboratory
Hereditary Cancer Genetics Requisition**

76 Stuart Street, Douglas 4, Room 8-415

Kingston, ON K7L 2V7

Tel: (613)549-6666 ext. 4892

FAX: 613-548-1356

In-house delivery tube station: #31

<http://www.kgh.on.ca/healthcare-providers/lab-requisition-forms>

Specimen Requirements

Collection Centre: _____ Collected by: _____ (please print)

Date (YYYY/MM/DD): ____/____/____ Time: _____ Collected at Room Temperature

Blood (EDTA -Lavender or Pink) Adult -10 cc Pediatric - 3 cc

Note: The requisition and specimen must carry the same two unique patient identifiers or the sample may be rejected

History

Has a mutation been found in another family member? Yes No Relationship to this patient: _____

If Yes, provide specific details (or copy of report): Gene: _____ Mutation: _____

Hereditary Breast/Ovarian Cancer Genetic Risk Information

Use disease specific risk categories described on back of requisition, circle all categories which apply to your patient. This information must be included.

Risk category: 1 2 3 4 5 6 7 8 9 10 11 12 13

Expedited testing (must meet one of criteria listed on back - please circle one of the following (see back of requisition: 1 or 2)

TEST REQUESTED:

Breast/Ovarian Cancer Panel Colorectal/Hereditary Gastric Cancer Panel Comprehensive Cancer Panel

(**the full gene list for all of these panels is provided on Page 2 of this requisition**)

BRCA1/BRCA2 only AJ Mutations DNA Banking

Family specific Mutation (attach copy of relative's report)

Report to: (Physician Information)

Name: _____ Phone (____) _____ FAX: (____) _____

Address: _____ City: _____ Postal Code: _____

CPSO#: _____ OHIP Billing #: _____ Signature: _____

(**For expedited testing, request must be authorized by ordering physician before sample sent **)

Internal Lab Use Only:

Place Label Here

RISK CATEGORIES FOR INDIVIDUALS ELIGIBLE FOR SCREENING FOR A GENETIC SUSCEPTIBILITY TO BREAST OR OVARIAN CANCERS

Testing for Affected Individuals with Breast or Ovarian Cancer.

At least one case of cancer:

1. Ashkenazi Jewish and breast cancer <50 years, or ovarian cancer at any age. Note: testing limited to ethnic specific mutations, unless other criteria given in this list are met.
2. Breast cancer <35 years of age.
3. Male breast cancer.
4. Invasive serous ovarian cancer at any age.

At least two cases of cancer on the same side of the family:

5. Breast cancer <60 years, and a first or second-degree relative with ovarian cancer or male breast cancer.
6. Breast and ovarian cancer in the same individual, or bilateral breast cancer with the first case <50 years.
7. Two cases of breast cancer, both <50 years, in first or second-degree relatives.
8. Two cases of ovarian cancer, any age, in first or second-degree relatives.
9. Ashkenazi Jewish and breast cancer at any age, and any family history of breast or ovarian cancer.

Note: testing limited to ethnic specific mutations, unless other criteria given in this list are met

At least three cases of cancer on the same side of the family:

10. Three or more cases of breast or ovarian cancer at any age.

Testing for Unaffected individuals (*this should be done only if affected individuals are unavailable i.e. deceased*)

11. Relative of individual with known BRCA1 or BRCA2 mutation. *Note: specific family mutation only tested.*
12. Ashkenazi Jewish and first or second-degree relative of individual with: breast cancer <50 years, or-ovarian cancer at any age, or-male breast cancer, or-breast cancer, any age, with positive family history of breast or ovarian cancer. *Note: testing limited to ethnic specific mutations, unless meet other criteria.*
13. A pedigree strongly suggestive of hereditary breast/ovarian cancer, i.e. risk of carrying a mutation for the individual being tested is >10%.

EXPEDITED TEST CRITERIA (only for Hereditary Breast/Ovarian Cancer)

1. Patient is currently receiving treatment for breast cancer. Expedited testing would allow the patient and doctor the option of proceeding with prophylactic mastectomy, instead of radiation therapy if she is found to carry a BRCA1 or BRCA2 mutation. If mastectomy is chosen, the patient can avoid unnecessary radiation and have the full range of option for reconstructive surgery. **AND**
Patients surgery or radiation therapy is to begin no sooner than 8 weeks from the date of blood draw, and before the results are expected, based on the current TAT for testing in the province. *Note: this criteria EXCLUDES elective reconstruction and/or prophylactic surgery as a reason for expedited testing, unless it is being done at the same time as surgery to treat the patient's cancer.*
2. Patient requires surgery for other urgent medical reasons (eg. Hysterectomy for uterine bleeding causing anemia) and may use the information to alter surgical decisions (eg. Salphingo-oophorectomy to be done with hysterectomy). **AND**
Patients surgery or radiation therapy is to be begin no sooner than 8 weeks from the date of blood draw, and before the results are expected, based on the current TAT for testing in the province. *Note: this does not include unaffected patients who want to make a decision about prophylactic surgery.*

LIST OF GENES:

BOC: ATM, BARD1, BRCA1, BRCA2, BRIP1, CDH1, CHEK2, EPCAM, FANCC, MLH1, MSH2, MSH6, NBN, PALB2, PMS2, PTEN, RAD50, RAD51C, RAD51D, STK11, TP53

CRC/HCG: APC, BMPR1A, CDH1, CHEK2, EPCAM, MLH1, MSH2, MSH6, MUTYH, PMS2, POLD1, POLE, PTEN, SMAD4, STK11, TP53

COMPREHENSIVE: All of the above, plus CDKN2A.