

CANCER GENETICS AND GENOMICS LABORATORY

HEREDITARY CANCER MULTI-GENE PANEL



BC CANCER 604-877-6000 EXT 67-2094
 DEPT. OF PATHOLOGY AND LABORATORY MEDICINE FAX: 604-877-6294
 ROOM 3307 - 600 WEST 10TH AVENUE MON-FRI 8:30AM-4:30PM
 VANCOUVER BC V5Z-4E6 WWW.CANCERGENETICSLAB.CA
GENETIC.COUNSELLOR@BCCANCER.BC.CA

CANCER GENETICS LAB
 SHIRE LABEL USE ONLY

PATIENT INFORMATION

Last Name		First and Middle Names	
Date of Birth (dd/mmm/yyyy)	Gender Male Female Non Binary/Other/Not Disclosed		
PHN	BC Cancer ID	Cerner MRN	
Email Address			

REQUESTING PHYSICIAN **NOTE: SIGNATURE REQUIRED (BELOW)**

Name	MSC
Phone	Fax
Address	
Email Address	

CONSENT

Your sample **may** be sent to a laboratory in the USA for testing. Your personal information (name, date of birth, sex, cancer history) would be sent with the sample.
 Please contact genetic.counsellor@bccancer.bc.ca if you have any questions or concerns.

Patient agrees to their personal health and genetic information (including test results) being shared with relatives referred for genetic assessment. Yes No

If patient is unable to receive their results, it should be disclosed to (or shared with):

Name	Relationship to patient	Contact Phone / Email
------	-------------------------	-----------------------

COPY PHYSICIANS (ALL INFORMATION IS NECESSARY)

Name	MSC
Fax - Mandatory to provide copy of genetic test report	
Name	MSC
Fax - Mandatory to provide copy of genetic test report	

SPECIMEN

Specimen Type	Collect 1 x 6mL EDTA blood. Store and ship at room temperature using overnight delivery to Cancer Genetics and Genomics Laboratory (address above). Do not refrigerate or freeze.	Collection Date (dd/mmm/yyyy)
Peripheral Blood		

INTERPRETER

Interpreter required?
No Yes, Language:

HEREDITARY CANCER TESTING INFORMATION

- This is a blood test to see if your cancer is hereditary. About 1 in 10 cancers are hereditary.
- If your cancer is hereditary, you will have an appointment with a genetic counsellor.
- Your test results may have implications for relatives.
- Your test results may be used to guide your cancer treatment and tell us about new cancer risks.
- Under the Canadian Genetic Non-Discrimination Act (GNDA), companies (including insurers) and employers cannot ask for your genetic test results or ask you to have genetic testing.
- Any unused samples may be stored at the BC Cancer Genetics & Genomics Laboratory and may be used to develop new clinical genetic tests in BC.

TEST REQUESTED

Hereditary Cancer Multi-Gene Panel Testing ^{SQ HCAGPB} If your patient requires expedited testing for treatment planning, please email genetic.counsellor@bccancer.bc.ca

ANCESTRAL BACKGROUND – SELECT ALL THAT APPLY

Africa / Caribbean	Asia East South/Central	Europe / UK	Indigenous (First Nations, Metis, Inuit)	Jewish Ashkenazi Sephardic	Middle East	South / Central America	Other
							Specify:

TESTING INDICATION(S) – SELECT ALL THAT APPLY

Breast Cancer ^(BRCA) HER2-negative breast cancer, eligible for adjuvant Olaparib Hereditary Breast and Ovarian Cancer ^(INHERCAN) Breast cancer ≤ age 35 Breast cancer age 36-50 and under active oncologic care 2 primary breast cancers at any age Triple negative (ER-PR-HER2-) breast cancer Ovarian, fallopian tube or peritoneal cancer (non-mucinous epithelial; incl. STIC) Male breast cancer	Prostate Cancer ^(INHERCAN) Metastatic prostate cancer Pancreatic Cancer ^(PANC CA) Pancreatic ductal adenocarcinoma (PDAC) Does patient have a first degree relative with PDAC? Yes No Unknown Pancreatic neuroendocrine tumour Medullary Thyroid Cancer ^(MTC) Medullary thyroid cancer Paraganglioma ^(PGL) Paraganglioma (includes pheo) Renal Cancer ^(RENAL) ≤ age 47	Ashkenazi Jewish Heritage ^(INHERCAN) Personal or family history of breast, ovarian, pancreatic, high-grade prostate cancer Other ^(INHERCAN) ** Approved by Hereditary Cancer Program ** Confirmation of pathogenic variant result (include relevant report(s) from tumour testing or clinical trial/research testing) ** INDICATION/VARIANT DETAILS (REQUIRED FOR TEST TO PROCEED):
---	--	--

PHYSICIAN SIGNATURE (REQUIRED) By signing below, I hereby acknowledge that I have informed the patient about the implications of hereditary testing.

DATE

LAB USE ONLY	PB EDTA	Other	HCP USE ONLY	Progeny	Initials	Date