CANCER GENETICS AND GENOMICS LABORATORY
HEREDITARY CANCER MULTI-GENE PANEL

BC CANCER
DEPT. OF PATHOLOGY AND LABORATORY MEDICINE
ROOM 3307 - 600 WEST 10TH AVENUE
VANCOUVER BC V5Z-4E6

604-877-6000 EXT 67-2094
FAX: 604-877-6294
MON-FRI 8:30AM-4:30PM
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 ☐ X ☐ Unknown	
PHN	BC Cancer ID	Cerner MRN
Email Address		

REQUESTING PHYSICIAN NOTE: SIGNATURE REQUIRED (BELOW)

Name	MSP
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 **MSP**

Fax - Mandatory to provide copy of genetic test report

Name **MSP**

Fax - Mandatory to provide copy of genetic test report

SPECIMEN

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

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.

ANCESTRAL BACKGROUND – SELECT ALL THAT APPLY

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

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

RELEVANT CLINICAL HISTORY / 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

Pancreatic Cancer (PANC CA)
☐ Pancreatic ductal adenocarcinoma (PDAC)
Does patient have a first degree relative with PDAC?
☐ Yes ☐ No ☐ Unknown
☐ Pancreatic neuroendocrine tumour

Prostate Cancer (INHERCAN)
☐ Metastatic prostate cancer

Colorectal Polyposis (INHERCAN)
☐ ≥10 adenomatous polyps ≤ age 60
☐ ≥20 cumulative adenomatous polyps at any age
☐ ≥2 hamartomatous polyps
☐ WHO criteria met for Serrated Polyposis Syndrome

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)

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