

# 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](http://WWW.CANCERGENETICSLAB.CA)  
[GENETIC.COUNSELLOR@BCCANCER.BC.CA](mailto: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)**

Last Name	First 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](mailto: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
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### COPY PHYSICIANS (ALL INFORMATION IS NECESSARY)

Last Name	First Name	MSP
Fax - Mandatory to provide copy of genetic test report		
Last Name	First Name	MSP
Fax - Mandatory to provide copy of genetic test report		

### SPECIMEN

Specimen Type Peripheral Blood	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) and Time
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### INTERPRETER

Interpreter required? No    Yes, Language:
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### 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 <sup>SQ HCAGPB</sup>    If your patient requires expedited testing for treatment planning, please email [genetic.counsellor@bccancer.bc.ca](mailto:genetic.counsellor@bccancer.bc.ca)

### RELEVANT CLINICAL HISTORY / TESTING INDICATION(S) – SELECT ALL THAT APPLY

<b>Breast Cancer</b> <sup>(BRCA)</sup> HER2-negative breast cancer, eligible for adjuvant Olaparib  <b>Hereditary Breast and Ovarian Cancer</b> <sup>(INHERCAN)</sup> 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	<b>Pancreatic Cancer</b> <sup>(PANC CA)</sup> Pancreatic ductal adenocarcinoma (PDAC) <i>Does patient have a first degree relative with PDAC?</i> Yes    No    Unknown  Pancreatic neuroendocrine tumour  <b>Prostate Cancer</b> <sup>(INHERCAN)</sup> Metastatic prostate cancer  <b>Colorectal Polyposis</b> <sup>(INHERCAN)</sup> ≥10 adenomas ≤ age 60 ≥20 cumulative adenomas at any age ≥2 hamartomatous polyps WHO criteria met for Serrated Polyposis Syndrome	<b>Medullary Thyroid Cancer</b> <sup>(MTC)</sup> Medullary thyroid cancer  <b>Paraganglioma</b> <sup>(PGL)</sup> Paraganglioma (includes pheo)  <b>Renal Cancer</b> <sup>(RENAL)</sup> ≤ age 47  <b>Ashkenazi Jewish Heritage</b> <sup>(INHERCAN)</sup> Personal or family history of breast, ovarian, pancreatic, high-grade prostate cancer  <b>Other</b> <sup>(INHERCAN)</sup> ** Approved by Hereditary Cancer Program ** Confirmation of pathogenic variant result (include relevant report(s) from tumour testing or clinical trial/research testing)
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**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
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