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)

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 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)

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	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 ☐ Results needed in 6-8 weeks for treatment (< 6 weeks place Urgent HCP referral).

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 adenomas ≤ age 60
☐ ≥20 cumulative adenomas 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

The personal information collected on this form is collected under the authority of the Personal Information Protection Act. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the Personal Information Protection Act and when applicable the Freedom of Information and Protection of Privacy Act and may be used and disclosed only as provided by those Acts.