WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

Cancer Genetics Program
2220 Kildare Road
Windsor, ON N8W 2X3
Phone: 519-254-5577 ext. 58620

Erie St. Clair Regional Cancer Program
Ontario Health (Cancer Care Ontario)

Cancer Genetics Referral Form

FAX: 519-255-8688

Referral date (DD/MM/YYYY): _____ ☐Female ☐Male ☐ Other: _____

Patient name: _____

DOB (DD/MM/YYYY): _____ Health Card #: _____

Address: _____ City: _____ Postal Code: _____

Tel (preferred): _____ Email: _____

Tel (alt): _____ Ashkenazi Jewish ancestry? ☐ Yes ☐ No

Interpreter req'd: ☐ No ☐ Yes, specify language: _____

Does your patient have a PERSONAL history of cancer? ****If YES, please send all relevant cancer pathology reports with referral****

☐ NO ☐ YES, type(s): _____ age(s) diagnosed: _____

Does your patient need to be seen URGENTLY? (i.e. for upcoming surgical decision-making or treatment options)**?**

☐ NO ☐ YES, reason for urgency & date of medical intervention: _____

Has your patient HAD GENETIC TESTING (incl. germline & tumour testing)**?** ****If YES, please send copies of all results with referral****

☐ NO ☐ YES, result: _____

Please check reason(s) for referral:

☐ Personal history suggestive of hereditary cancer syndrome (*see OH's* Referral Guidance for Hereditary Cancer Genetic Assessment)

Please specify: _____

_____

_____

☐ Family history suggestive of hereditary cancer syndrome (*see page 2 for outline of current genetic testing criteria*)

Please specify family history including types of cancer, ages of diagnosis, and relationships to patient: _____

_____

_____

_____

_____

_____

☐ Family member with a known hereditary cancer gene mutation (i.e. *BRCA1, BRCA2, MLH1, MSH2, MSH6, PMS2, TP53*)

Gene: _____

Relative's full name & DOB: _____

Relative's biological relationship to patient (e.g. maternal aunt): _____

Genetics clinic where relative seen: _____

Referring physician: _____ Billing number: _____

Address: _____

Tel: _____ Fax: _____