UHN Princess Margaret Cancer Centre

Bhalwani Familial Cancer Clinic
CONSULT REQUEST FORM
610 University Ave 700U-6W390
Toronto, ON, M5G 2M9
FAX: 416-946-6528
PHONE: 416-946-2270

NAME:
MRN:
HC#:
DOB:
ADDRESS:
PHONE #:
MALE ☐ FEMALE ☐

REFERRING PROVIDER INFORMATION:

Staff Physician:_____ Signature:_____

Date: _____ Phone:_____ Fax: _____

Interpreter required:	Questionnaires given to patient:	☐ **URGENT** ***(please provide reason):***
☐ No ☐ Yes, language: _____	☐ No ☐ Yes	_____

REASON FOR CONSULTATION:

Personal Diagnosis of Cancer: ☐ No ☐ Yes *(please fill below)*

☐ Breast /DCIS: age at diagnosis: _____ ☐ Triple negative ☐ Bilateral: age at 2nd diagnosis: _____	☐ Renal: age at diagnosis: _____ ☐ Bilateral ☐ Clear cell ☐ Non-clear cell:_____
☐ Ovarian: age at diagnosis: _____ ☐ **S**erous ☐ Non-serous: _____	☐ Prostate: age at diagnosis: _____ ☐ Metastatic ☐ Cribriform/Intraductal
☐ Endometrial: age at diagnosis: _____ ☐ **S**erous ☐ Non-serous: _____	☐ Endocrine tumour/cancer: age diagnosis: _____ Type: _____
☐ Melanoma: age at diagnosis: _____ ☐ Uveal ☐ Cutaneous:	☐ Other: _____ _____

Previous Germline Testing (if applicable):
☐ Positive: Gene: _____ ☐ Negative ☐ VUS
Tumour / ctDNA testing results (if applicable):
☐ Positive: Gene: _____ *(please provide a copy of report if possible)*

Family History of Cancer: ☐ Yes ☐ No ☐ Adopted	Ashkenazi Jewish ancestry: ☐ Yes ☐ No
☐ Breast	☐ Prostate
☐ Bilateral	☐ Pancreatic
☐ 1 relative with breast cancer at ≤ 35 years	☐ Renal
☐ 1 relative with breast cancer ≤50 years	☐ Melanoma
☐ 1 relative with breast cancer >50 years	☐ Colon
☐ 2 or more relatives with breast cancer at any age	☐ Endometrial
☐ Male breast cancer	☐ Leukemia / Lymphoma
☐ Ovarian	☐ Other cancer/tumour(s):_____

☐ **An identified genetic mutation in any blood relative** *(please provide a copy of report if possible)*
Gene: _____ Relationship to patient: _____