Alberta Health Services

LOIS HOLE HOSPITAL FOR WOMEN

Patient Label

Allard Hereditary Breast and Ovarian Clinic
Referral Form
Fax to: (780) 735-5611/ Booking number: 780-735-6642

Date of Referral (mm/dd/yyyy):_____

Patient Information:

Name:_____ PHN:_____

Address:_____ Home #:_____

City: _____ Postal Code:_____

Work #:_____ Cell#: _____ Birth date (mm/dd/yyyy):_____

Referral to: ☐ Breast Specialist ☐ GyneOncology ☐ Both

The following Referral Criteria **MUST** be met, ***please indicate all applicable***:

Patients age **25 to 70** and have not had bilateral mastectomies (exception GyneOncology only referral) and one of the following:

- ☐ Patients who are **recommended** for follow up by a **Genetics Clinic** (with >20% and lifetime risk)
- ☐ Patients who have a mutation to **BRCA1 or BRACA2** (please include documentation from Genetics Clinic)
- ☐ **First degree relative** of patients who have a documented **mutation of BRCA1 or BRCA2**
- ☐ Family members of patients in the clinic who have a recommendation by HBOC clinicians
- ☐ Women with history of **radiation treatments to the thorax** before the age of 30

Strong family history of breast and /or ovarian cancer on same side of family:

- ☐ Two family members with breast cancer if:
  - ☐ One has been diagnosed with bilateral breast cancer
  - ☐ One is male
  - ☐ Both people were diagnosed with breast cancer **under the age of 50**
- ☐ Three family members with breast cancer one of whom is **under the age of 50** (this may span two generations)
- ☐ Four family members with breast cancer
- ☐ A single individual who has had breast cancer and a confirmed ovarian cancer* (either first degree relative or paternal aunt)
- ☐ A diagnosis of breast cancer and confirmed ovarian cancer* on the same side of the family.

* Ovarian cancer refers to invasive non0mucinous epithelial ovarian cancer, includes cancer of the fallopian tubes or primary peritoneal cancer, excludes borderline or low malignant potential ovarian tumor.

NOTE: Family members should be blood relations to each other and the referred patient

Please include history including any previous cancers and where they were treated:_____

_____

Date of last imaging (Mammogram, U/S, MRI) _____ please include copy of reports.

Current or Previous Breast Concerns:_____

Referred by:

Name: _____ Practice ID:_____

Address: _____

City: _____ Postal Code: _____

Office Phone:_____ Fax Number: _____

NOTE: If patient has a new or suspicious breast finding, please refer to Comprehensive Breast Care Program at 780-638-2227 or fax: 780-643-4488.