

**Allard Hereditary Breast and Ovarian Clinic**  
**Referral Form**

**Fax to: (780) 735-5611/ Booking number: 780-735-6642**

Date of Referral (mm/dd/yyyy): \_\_\_\_\_

<b><u>Patient Information:</u></b>	
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:*** (Incomplete referrals will be returned)

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% lifetime risk)
- Patients who have a mutation associated with an increased risk of breast cancer such as **BRCA1 or BRCA2** (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 non-mucinous 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 attach 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: \_\_\_\_\_

<b><u>Referred by:</u></b>	
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 780-613-5090 or fax: 780-641-9523**