Alberta Health Services

LOIS HOLE HOSPITAL FOR WOMEN

Patient Label

Allard Hereditary Breast and Ovarian Clinic (HBOC)
Referral Form
Fax to: (780) 735-5611 / Clinic number: (780) 735-4718

Date of Referral: _____

Patient Information:

Name:_____ PHN:_____

Address:_____ Home #:_____

City: _____ Postal Code:_____

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

Referral Criteria – Breast

1. Women age **25 to 70** who have not had bilateral mastectomies
2. Women who have a breast or ovarian cancer gene mutation **(please include documentation)**
3. **First degree relatives** of patients who have a documented breast or ovarian cancer gene mutation
4. Women with a history of radiation treatment to the thorax before the age of 30
5. **Strong family history**
   - 2 family members with breast cancer if:
     1. One has bilateral breast cancer (does not include women who have had a prophylactic mastectomy on one side **OR**
     2. One is male **OR**
     3. Both people were diagnosed with breast cancer under the age of 50
   - 3 family members with breast cancer, two of whom is under the age of 50
   - 4 family members with breast cancer

NOTE: Family members should be blood relations and from the same side of the family

Referred by:

Name: _____

Address: _____

City: _____ Postal Code: _____

Office Phone:_____ Fax Number: _____

*****The HBOC clinic will follow gene positive women for high risk screening. For all other patients, the clinic will provide a consultation and breast screening recommendations.*****