Risk Assessment for Hereditary Cancer Syndromes

Patient Name:_____Date of Birth: _____ Date _____ Insurance Carrier_____

Women's Clinic of Northern Colorado is dedicated to improving your quality of care, committed to your health, and helping with cancer prevention. To best serve you, we need a detailed personal and family cancer history.

Please consider the following Family Members when completing this form: (Blood Relatives Only)

- Mother, Father, Sister, Brother, Children: **(1st degree relatives)**
- Aunt, Uncle, Grandmother, Grandfather, Grandchild, Niece, Nephew, Half Siblings: **(2nd degree relatives)**
- Cousins, Great Grandparent, Great Aunt, Great Uncle: **(3rd degree relatives)**

YOUR FAMILY'S Cancer History (Please be thorough and accurate. Please include BIOLOGICAL FAMILY ONLY)

	CANCER	YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
☐ Y ☐ N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	OTHER CANCER(S) (SPECIFY):							

☐ Y ☐ N Are you of Jewish descent?
What is your Ancestry:_____

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? If yes, please explain:

Cancer Risk Assessment Review and Counseling

Patient's Signature:_____ Date: _____
Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED (patient signature below)

Informed Refusal Documentation

My provider, has recommended the BRACAnaylsis and/or Colaris and/or myRISK genetic test based on my personal and/or family history of cancer. He/She has explained to me the potential benefits of the genetic test and the risks of not consenting to the genetic test. Despite my provider's recommendation, I decline to consent to the genetic test.
Signature of patient for informed refusal_____

For Office Use Only:

Hereditary Breast and Ovarian Cancer Syndrome

- Breast cancer diagnosed at or under age 45*
- Ovarian cancer at any age*
- 2 primary breast cancers in the same person w/ 1 diagnosed at or under age 50**
- 2 relatives same side of the family w/ breast cancer, 1 diagnosed at or under age 50**
- 3 or more of the following cancers at any age on the same side of the family: breast, ovarian, pancreatic, prostate**
- Triple negative breast cancer at or under the age of 60*
- Male breast cancer*
- Ashkenazi Jewish ancestry with an HBOC*** associated cancer*

Lynch Syndrome

- 1 Colon, rectal or uterine cancer diagnosed at or under age 50*
- 2 or more w/ a Lynch syndrome cancer****, 1 before the age of 50 and 1 being colon, rectal or uterine cancer**
- 3 or more w/ a Lynch syndrome cancer**** at any age and one being colon, rectal or uterine cancer**

***Self, 1st, 2nd degree family members**
****Self, 1st, 2nd, or 3rd degree family members**
*****HBOC associated cancers: Breast, ovarian, pancreatic**
******Lynch associated cancers: Colon, uterine, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas**