Hereditary Cancer Service / Genetic Counseling

NAME: _____DATE OF BIRTH_____

APPOINTMENT DATE/TIME_____APPOINTMENT LOCATION_____

Thank you for choosing Centura for hereditary cancer genetic counseling. We look forward to meeting with you.

WHAT YOU SHOULD KNOW ABOUT GENETIC COUNSELING AND CANCER RISK ASSESSMENT

Frequently Asked Questions

How long is the appointment? On average 45 minutes to one hour.

What information do I need to provide prior to the appointment?

- Gather information about cancers in your family
  - Mother AND father's side

- If you or family members have been diagnosed with cancer:
  - Where the cancer started and at what age.

What will we review and discuss at our appointment?

- How your family and medical history effect your risk for cancer or your family's risk for cancer

- Appropriate cancer screening based on your risk

- The pros and cons of genetic testing (if you are eligible for testing)

- How genetic testing results might impact your medical care and the medical care of your family members

- Review the process the laboratory will use to determine and notify you of out of pocket expenses. We are not able to check your insurance coverage for GENETIC TESTING prior to our meeting. Whether or not you meet your insurance company's criteria for testing and review of your family history during the appointment will help determine if genetic testing is warranted

- The appropriate genetic test to order and laboratory options.

Sincerely,

The Hereditary Cancer Service Staff

Directions for Completing the History Form

Careful completion of your family history is very important since your risk assessment depends on this information. Many times the information we request is difficult to obtain. Do your best and we will work with the information you have.

Instructions for completing questionnaire:

- Please answer all questions and fill out all columns as completely as possible.
- Please record ALL RELATIVES (even if they have not had cancer or another disease)
- Provide as much information as possible about current ages, ages at death, and ages of diagnosis of disease. ***Approximate ages are better than not listing ages at all. This information will help facilitate an accurate risk assessment.***
- Write "UNK" (unknown) if you do not know or "NA" (not applicable) if the information requested does not apply.
- For relatives that were found to have colon polyps include the number of polyps they had and the age at which they were found.
- If females have had their ovaries removed, please write at what age this surgery took place.

Comments:	In the space below, put any comments or additional information you have about relatives who have had cancer or one of the conditions asked about on the Family History page. If you need an additional space, please use a separate piece of paper

Space for Additional Information:

YOUR HEALTH and BACKGROUND

Name _____ Date of Birth_____

Who is your primary care physician? _____

Race: White / Black / Asian / Native American / Hawaiian or Pacific Islander / Mixed race

Ethnicity:

Are you of Ashkenazi Jewish descent? Yes No

Do you consider yourself to be Hispanic or Spanish? Yes No

Are your family members from San Luis Valley or Northern New Mexico? Yes No

Please list any health issues, surgeries, biopsies you have had and at what age?

Have you undergone Colon or intestinal Screening? Yes No

If yes- any polyps found? Yes No

How many and at what age? _____

Does anyone in your family have a known genetic mutation? Yes No

If yes, who? _____

What gene was tested? _____

Are you able to obtain a copy of the report? Yes No

If you are <u>female</u> and <u>do not</u> have a history of breast cancer, please answer the following questions:

Age at time of first menstrual period _____ Age at time of first live birth _____

Do you have a history of breast biopsies? Yes No

If yes, how many? _____

Do you have a history of atypical hyperplasia on biopsy? Yes No

Do you have a history of LCIS on biopsy? Yes No

Have you gone through menopause? Yes No

If yes, at what age?_____

If you used Hormone Replacement therapy, what type? _____

How many years? _____ Are you still taking hormones? Yes No

If no when did you stop taking hormones? ____ 5 or more years ago

____Less than 5 years ago

IMMEDIATE FAMILY:

Family Member	NAME	Living?	Current age or age at death	Gender	Illness/Disease/ Type of Cancer	Age of illness onset	Cause of death
Example: Cousin	Jane	☐ Yes ☒ No	38	☒ Female ☐ Male	Breast Cancer	30	Heart Attack
You		Yes		☐ Female ☐ Male			
Spouse		☐ Yes ☐ No		☐ Female ☐ Male			
Children (if your children have different parents, please write the parent's name in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
Your Father		☐ Yes ☐ No		Male			
Your Mother		☐ Yes ☐ No		Female			
Brothers and Sisters (if you have half siblings, please indicate the shared parent in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			

IMMEDIATE FAMILY (continued):

Family Member	NAME	Living?	Current age or age at death	Gender	Illness/Disease/ Type of Cancer	Age of illness onset	Cause of death
Nieces and Nephews (please write the name of your brother or sister, who is the parent, in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
Grand-children (please write the name of your child, who is the parent, in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			

FATHER'S SIDE OF FAMILY:

Family Member	NAME	Living?	Current age or age at death	Gender	Illness/Disease/ Type of Cancer	Age of illness onset	Cause of death
Your Grand-father		☐ Yes ☐ No		Male			
Your Grand-mother		☐ Yes ☐ No		Female			
Aunts and Uncles (if your aunts and uncles have different parents, please write the parent that is shared in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
Cousins (please write the name of your aunt or uncle, who is the parent, in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			

MOTHER'S SIDE OF FAMILY:

Family Member	NAME	Living?	Current age or age at death	Gender	Illness/Disease/ Type of Cancer	Age of illness onset	Cause of death
Your Grand-father		☐ Yes ☐ No		Male			
Your Grand-mother		☐ Yes ☐ No		Female			
Aunts and Uncles (if your aunts and uncles have different parents, please write the parent that is shared in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
Cousins (please write the name of your aunt or uncle, who is the parent, in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			

List health care providers/ others that you would like to receive genetic counseling/genetic testing information:

This authorization is permanent unless otherwise noted here:

_____

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, guardian, personal representative, etc)