Cancer Genetics Referral Intake Form

Please complete this form with your patient as part of the referral to Medical Genetics. This information will be used to determine if your patient meets our referral criteria for genetic counselling and possible genetic testing. This information, as well as a referral form or letter, can be faxed to Medical Genetics at (306)655-1736. Please contact us at (306)655-1692 if you have any additional questions. The referral form as well as this intake form can be found at: https://www.saskatoonhealthregion.ca/locations_services/Services/Medical-Genetics.

Name (Last, First): _____ **Date of birth** (dd/mm/yy):_____

PHN:_____ **Referring Physician**:_____

1. Has this patient had a cancer diagnosis? **Yes/No**
   If yes, please specify the primary site(s) and age(s) at diagnosis:_____
2. **Family history of cancer**. Please include the following information, to the best of your knowledge, for closely related individuals in the family (children, siblings, parents, grandparents, aunts/uncles, first cousins).

Siblings and Children

Relationship	Cancer Diagnoses	Age at diagnosis	Place of Residence/Treatment	Living? Y/N

Maternal Family History

Ethnic Background (eg. English, German, Ashkenazi Jewish, Mennonite, etc.): _____

Relationship	Cancer Diagnoses	Age at diagnosis	Place of Residence/Treatment	Living? Y/N

Paternal Family History

Ethnic Background (eg. English, German, Ashkenazi Jewish, Mennonite, etc.): _____

Relationship	Cancer Diagnoses	Age at diagnosis	Place of Residence/Treatment	Living? Y/N

3. Has anyone in the family been seen by Genetics or had genetic testing? **Yes/No**
   If yes, please specify (name, location of testing): _____

Please note that if this referral is accepted, additional information will be required at the time of the appointment. An accepted referral does not guarantee genetic testing will be offered.