NORTH YORK GENERAL
Making a World of Difference

REFERRAL FORM

The Charlotte and Lewis Steinberg Familial Cancer Clinic

Referral Date:

PATIENT NAME: _____

DOB: _____ ☐ **Male** ☐ **Female**
yy / mm / dd

Health card #: _____
Version code

Address: _____

_____
City **Postal code**

Best phone #: _____ **Alternate#:** _____

Patient affected with cancer?
☐ **No** ☐ **Yes**

Type of cancer _____

(*Please send most recent mammogram, pathology/surgical report*)

Recent Diagnosis? (*in last 3 months*)
☐ **No** ☐ **Yes**

Interpreter needed: ☐ **No** ☐ **Yes**

Language: _____

Referrals to genetics must meet one of the following referral criteria (*please check the box that applies)*:

- ☐ Family history of multiple cases of the same cancer (at least one diagnosed <50) on the same side of the family- especially in first and second degree relatives over more than one generation
- ☐ Breast cancer at age 45 or under (50 or under if adopted)
- ☐ Triple negative breast cancer at 60 years or under
- ☐ Male breast cancer diagnosis
- ☐ Pancreas cancer diagnosis
- ☐ Metastatic prostate cancer diagnosis
- ☐ Breast and/or ovarian and/or colon cancer in Ashkenazi Jewish families
- ☐ Family history of a known familial pathogenic variant in a cancer gene (*please include family member's results report*)
- ☐ Other, please specify_____

Comments: _____

REFERRING DOCTOR: _____ **Physician billing #:** _____

Address: _____

Phone # _____ **Private #** _____ **Fax #** _____

PLEASE NOTE: ★ **Incomplete or illegible referral will be returned to your office**

Most patients will be contacted directly by a mailed questionnaire

Please fax to the Charlotte and Lewis Steinberg Familial Cancer Clinic at 416-756-6727

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