Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician Name: _____

Date of Birth: _____ Today's Date: _____

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) for any statement below, you may be appropriate for hereditary cancer testing. When you circle Y, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer.

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**

Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives** Cousin/Great Grandparent = **3rd Degree Relatives**

Have you or any of your relatives been tested for hereditary cancer (HBOC/BRACAnalysis or Lynch/COLARIS)? YES NO

Have you ever been diagnosed with cancer? What site: _____ What age: _____

		COLON AND UTERINE CANCER (COLARIS)	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Uterine (endometrial) cancer before age 50				
Y	N	Colorectal cancer before age 50				
Y	N	Two or more of the following cancers on the same side of the family: colon, uterine (endometrial), ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis				
Y	N	A family member with a known Lynch Syndrome mutation				

		BREAST AND OVARIAN CANCER (BRACAnalysis)	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer under the age of 50				
Y	N	Three relatives on the same side of the family with breast and/or ovarian cancer at any age				
Y	N	Triple negative breast cancer under the age of 60 (receptor status negative for ER, PR and HER2)				
Y	N	Male breast cancer at any age				
Y	N	Breast or ovarian cancer in Ashkenazi Jewish family members				
Y	N	Pancreatic cancer with 2 or more breast and/or ovarian cancers on the same side of the family				
Y	N	A family member with a known BRCA mutation				

Are you of Jewish descent? YES NO

Is there any other cancer in you or any family members not listed above? If yes, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer:

_____

Patient's signature: _____ **Today's Date:** _____

FOR OFFICE USE ONLY

- € Patient is appropriate for further risk assessment and/or genetic testing
- € Information given to patient to review
- € Follow-up appointment scheduled on _____
- € Patient offered genetic testing: Accepted OR Declined HCP Signature: _____