RISK ASSESSMENT FOR HEREDITARY CANCER SYNDROMES

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please indicate those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side).

CANCER DIAGNOSIS	RELATIONSHIP (Parents, Siblings, Children, Aunts/Uncles, Grandparents, First Cousins, Nieces/Nephews	SPECIFICS
☐ Metastatic prostate cancer		Gleason(s): Age(s) of Diagnosis:
☐ Higher grade prostate cancer (Gleason 7 or greater) ***AND*** a family member with **ANY** of the following:		Gleason(s): Age(s) of Diagnosis:
• Breast cancer ≤50 years		Age(s) of Diagnosis:
• Ovarian cancer at any age		Age(s) of Diagnosis:
• Pancreatic cancer at any age		Age(s) of Diagnosis:
• Higher grade prostate cancers (Gleason 7+ or metastatic) at any age		Gleason(s): Age(s) of Diagnosis:
Other:		Age(s) of Diagnosis:

☐ You or someone in your family has had genetic testing for a hereditary cancer syndrome.

Explain: _____

_____
Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing

☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: _____

☐ Patient offered genetic testing:
- ☐ Accepted
- ☐ Declined

_____
Healthcare Professional's Signature Date

Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.MyriadPro.com/guidelines

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