

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

Patient Name: _____

Physician: Elana Cossetti

Date of Birth: _____

Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. **You and the following family members should be considered:**

Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y N Uterine (endometrial) cancer before age 50			
Y N Colorectal cancer before age 50			
Y N Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

*Lynch syndrome associated cancers include: colon/rectal, uterine/endometrial, ovarian, stomach/gastric, kidney/urinary tract, biliary tract, small bowel, pancreas, brain, and sebaceous adenoma/carcinoma

BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y N Breast cancer before age 50			
Y N Ovarian cancer			
Y N Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y N Male breast cancer			
Y N Triple negative breast cancer† (ER-, PR-, HER2- pathology)			
Y N Three or more HBOC-associated cancers at any age‡§			
Y N Ashkenazi Jewish ancestry and a personal or family history of an HBOC-associated cancer at any age‡§			

†HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer.

§Family members include first-, second- and third-degree relatives on both your mother and father's sides.

Y N Have you or any member of your family ever been tested for hereditary risk of cancer?
If yes, please explain: _____

Patient's Signature _____

Date _____

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- ☐ Candidate for further risk assessment and/or genetic testing: ☐ Lynch ☐ HBOC
- ☐ Information given to patient to review
- ☐ Follow-up appointment scheduled Date: _____

☐ Patient offered genetic testing:
☐ Accepted ☐ Declined

Healthcare Professional's Signature _____

Date _____

† For a better understanding of triple negative breast cancer, please ask your healthcare provider.

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

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