UCLA Health

MRN:
Patient Name:

(Patient Label)

RISK ASSESSMENT FOR LYNCH SYNDROME AND HEREDITARY BREAST AND OVARIAN CANCER SYNDROME

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

1st Degree Relatives = Mother/Father/Sister/Brother/Children
2nd Degree Relatives = Aunt/Uncle/Grandparent/Niece/Nephew
3rd Degree Relatives = Cousin/Great Grandparent

☐ **Yes** ☐ **No** 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?

If yes, what kind: _____ At what age: _____

BREAST AND OVARIAN CANCER (BRACAnalysis)			SELF	Family Member (Mother's Side)	Family Member (Father's Side)	Age At Diagnosis
☐ **Y**	☐ **N**	Breast cancer at age 50 or younger				
☐ **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[1] (ER-, PR-, HER2- pathology)				
☐ **Y**	☐ **N**	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
☐ **Y**	☐ **N**	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				

[1] For a better understanding of triple negative cancer, please ask your healthcare provider.

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COLON AND UTERINE CANCER (COLARIS)			SELF	Family Member (Mother's Side)	Family Member (Father's Side)	Age At Diagnosis
☐ **Y**	☐ **N**	Uterine (endometrial) cancer before age 50				
☐ **Y**	☐ **N**	Colon cancer before age 50				
☐ **Y**	☐ **N**	Two or more (at any age) 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				

☐ **Yes** ☐ **No** 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 kind/site of their cancer and their age when they were diagnosed:

_____

_____

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____ Date _____ Time _____

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☐ Patient is appropriate for further risk assessment and/or genetic testing
☐ Lynch ☐ HBOC

☐ Information given to patient to review

☐ Follow–up appointment scheduled on Date: _____

☐ Patient offered genetic testing:
☐ Accepted ☐ Declined

Physician Signature _____ ID # _____ Date _____ Time _____