LINCOLN SURGICAL ASSOCIATES, LTD

340 West Lincoln Street, Suite 500
Belleville, IL 62220
618.277.7400 **Phone**
618.277.7422 **Fax**

Risk Assessment for Hereditary Breast and Ovarian Cancer Syndrome

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

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; one breast cancer before 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	One relative with TWO separate breast cancers; one diagnosed before the age of 50 (in self, first or second degree family members)				
Y	N	Triple negative breast cancer under the age of 60 (receptor status negative for ER, PR, and HER2) (in self, first or second degree family members)				
Y	N	Male breast cancer at any age (in self, first or second degree family members)				
Y	N	Breast or ovarian cancer at any age in Ashkenazi Jewish family members				
Y	N	Pancreatic cancer with two 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 your mother still living?_____ **If yes, how old is she?**_____ **If no, how old was she when she passed away?**_____

How many sisters do you have?_____ **What are their current ages?**_____

How many daughters do you have?_____ **What are their current ages?**_____

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

FOR OFFICE USE ONLY

- ❑ **Patient is appropriate for further risk assessment and/or genetic testing**
- ❑ **Patient offered genetic testing:** **Accepted** **OR** **Declined** **HCP Signature:** _____
- ❑ **Patient scheduled to return for testing:**

Patient signature (if testing is declined): _____ **Reason for decline:** _____