

Please complete **ALL** sections and send a copy to the Regional Molecular Diagnostic Service, Belfast City Hospital accompanied by our standard genetics blood collection form and patient consent

Targeted Cancer Panel testing (R208): Inherited Breast Cancer

Northern Ireland Regional Molecular Diagnostic Service

Clinical genetics enquiries Email: genetic.medicine@belfasttrust.hscni.net Phone: 028 9504 8022
Lab enquiries Email: geneticslabs@belfasttrust.hscni.net Phone: 028 9504 7353

Patient Details

Full name: DOB:
NHS no: Diagnosis: Age at diagnosis:

Further personal/family history of cancer:

Please indicate whether there are any other family members who have been affected by cancer, and any details known (e.g. type, age at diagnosis, any genetic testing done/results).

If there is a known familial gene change (e.g. a BRCA mutation) please indicate here, provide details of the affected family member AND contact the on-call genetic counsellor to discuss.

Will the results influence near clinical management?
If yes, specify (including timeframe):

Additional comments:

E.g. stored sample details, indication that sample is to be arranged in due course, any other relevant details.

Referring Clinician Details-referrals will be accepted from the following (tick as appropriate)

Consultant oncologist ☐
Consultant breast surgeon ☐
Other- please specify below ☐

Full name:
Hospital:
Department:
Email:
Consultant:
(referrals without a named consultant will be refused)

Including your email here is **very important** for any further contact required.

This section **MUST** have a **named consultant**- those without this will not be processed

Indication for testing - patient **must** meet one of the following (tick as appropriate)

☐ Breast cancer* <40 ☐ Triple positive breast cancer <35
☐ Triple negative breast cancer <60 ☐ Breast cancer <45 AND a one or more first-degree relative with breast cancer <45
☐ Bilateral breast cancer <50
☐ Male breast cancer (any age)

* Breast cancer definition includes high grade DCIS

Patients who do not have any of the above indications may still be eligible for genetic testing **through the clinical genetics service**. Details of additional criteria can be found on page 2 of the FAQ document.

Panel genes- the following will be analysed:

Inherited Breast Cancer Panel
ATM, BRCA1, BRCA2, CHEK2, PALB2, PTEN, RAD51C, RAD51D, STK11, TP53

If there is an additional family history of **ovarian*** and/or **colorectal cancer** your patient would likely be eligible for a wider panel to include additional relevant genes. In this case, **send a blood sample** and **contact the on-call genetic counsellor** to discuss.

* Fallopian Tube and Primary Peritoneal cancers can be included

Please provide as many clinical details as possible about the patient.

A minimum of **three patient identifiers** are required to proceed with testing (full name, DOB, NHS no).

E.g. surgical management, treatment choices, clinical trial eligibility

Genetic testing can be requested by these specialties.

'Other' may refer to healthcare professionals who have the appropriate competency to offer their patients genetic testing.

State the indication for testing:
If patient does not meet any of these criteria, but meets any of the indications listed on page 2 of the FAQ document, they should be referred to the genetics service.

Please provide as many clinical details as possible about the patient.

A minimum of **three patient identifiers** are required to proceed with testing (full name, DOB, H&C number).

Key points to discuss when taking patient consent. Further guidance on how to explain these points can be found on page 9 (section 20) of the FAQ document

Patient consent must be recorded in this section with their signature.

The 'Diagnostic' box should be ticked in the case of diagnostic genetic testing for a patient affected by cancer.

Patient Details (or affix patient label)					
Surname:			Pedigree:		
Forename:			Referring Consultant:		
Health & Care No:			Email Address:		
DOB:			Dept./Ward/Hospital:		
Gender: M / F / Unspecified			Patient Address/Postcode:		
Ethnicity and Country of Origin:					
Record of Discussion regarding testing and/or storage of genetic material (for more details P.T.O) <i>I have discussed genomic/genetic testing with my health professional and I understand that:</i> 1) Testing is for diagnostic purposes. 2) My sample will be stored and used for future testing/quality assurance. 3) My sample/data may be shared with other health professionals for the benefit of relatives/diagnostic purposes. 4) Clinically actionable incidental findings detected by testing procedures may be reported. 5) My data is stored to enable future interpretations. 6) Results from my test will be stored electronically and form part of my health record.					
Patient/Parent Signature: _____			Consultant Signature: _____		
Print Name: _____			Print Name: _____		
Date Sample taken:		Time Sample taken:		Sample taken by:	
If several requests, please write order of testing, rather than just tick box					
Blood LI-HEP TUBE		Blood EDTA TUBE - DNA EXTRACTION		OTHER SAMPLE TYPES	
CELL CULTURE					
KARYOTYPE		MICROARRAY		Amniotic Fluid	
		CARRIER		Bone Marrow	
		Export/Send Away		CVS	
		DIAGNOSTIC (gene/panel screen)		Products of conception (POC)	
		PREDICTIVE		Skin/Tissue	
		RESEARCH		Saliva/Buccal	
		AFFECTED		Cord Blood	
		PRENATAL		OTHER	
		CONFIRMATION			
		POSSIBLY AFFECTED			
		OTHER			
Please specify if patient has had a bone marrow transplant or blood transfusion:					
Please Provide: All Relevant Clinical Details, Gene panel/Test Requested plus Testing Criteria Form, Family mutation and proband details (where applicable) including name, relationship and DOB.					

These sections MUST have a **named consultant**- those without this will not be processed

In this section you may add any additional information about the patient that you feel is relevant. However, this form must be accompanied by the R208 panel testing criteria form which is where you will indicate which testing criteria the patient meets, and any relevant family history information.

In the case of diagnostic testing for breast cancer patients, these sections should be ignored.

PATIENT LEGEND	
BONE MARROW SAMPLE	Please state disease (Leukaemia, Lymphoma, Myeloma etc.)
	Diagnostic - * Yes / No Follow up - * remission / relapse (*delete as appropriate)
	Bone Marrow transplant (specify sex of donor)
REQUIRED FOR ALL FETAL SAMPLES:	Mother's name Mother's date of birth
	Gestation
LABORATORY USE ONLY	
Sample type:	Laboratory Label(s)
Volume/ condition:	
Specimen entry:	
Duty Scientist Check:	
Sample Labelling:	
Sample labelling check:	
Date Received:	Time Received: