Hereditary Cancer Risk Assessment Program

Greater Baltimore Medical Center
The Harvey Institute for Human Genetics

Thank you for your interest in our hereditary cancer risk assessment program. In this packet, you will find information regarding our program. The next page covers "Frequently Asked Questions," which will hopefully address many of your questions.

If you are interested in scheduling an appointment, please complete the pre-visit questionnaire part of this packet and send it back to us either via e-mail, fax, or mail. **IF MAILING, PLEASE DO NOT SEND THIS PAPERWORK BACK TO US DOUBLE-SIDED.** This information is important for your visit and required prior to your appointment.

How to Contact Us:

Phone: (443) 849-3131
Email: clinicalgenetics@gbmc.org
Fax: (443) 849-2919

Our Web Site:

www.gbmc.org/cancergenetics

Our Location:

Greater Baltimore Medical Center
6701 N. Charles St, Ste 2326
Towson, MD 21204

We are located on the 2nd floor of the main hospital near labor and delivery.
Valet parking is available outside the maternity entrance,
or the nearest parking garage is the Lily garage.

Note: If you park in the Lily garage, we recommend you consider walking down the hill outside rather then through the hospital as this it the most direct route. If you walk through the hospital, follow the signs to Zone C/D for labor and delivery.

Frequently Asked Questions

What is the purpose of a hereditary cancer risk assessment?
We assess the likelihood of a genetic risk factor for cancer in you and/or your family based on information about your personal and family history. We may recommend genetic testing, additional or more frequent cancer screening , and/or ways to reduce cancer risk.

Will my insurance cover the cost of the visit and any genetic testing?
Yes, most likely. The visit and any genetic testing are billed separately to your insurance. For the visit, we accept all insurances with which GBMC maintains contracts. Our administrative staff would be happy to assist you in determining if your insurance maintains a contract with GBMC. If you are subject to a co-pay, co-payments are at the specialist rate. If your insurance requires a referral to see a specialist, it is your responsibility to obtain this prior to your appointment.

Any genetic testing is sent to outside laboratories and billed by that laboratory. In our experience for most of our patients, genetic testing is covered by their insurance. However, once we determine what type of testing would be most appropriate we will be able to provide you with additional information regarding your insurance coverage for genetic testing. Unfortunately, we are usually not able to provide this information before your initial visit, as coverage is usually based upon our risk assessment.

My insurance requires prior authorization for genetic testing, should my physician or I get this before my visit?
No. If prior authorization is required, we or the laboratory will obtain this on your behalf prior to the start of any testing. In order to obtain prior authorization a letter of medical necessity is usually required, which we can write once we have reviewed your personal and/or family history. Please note that if prior authorization is required prior to testing, we are often still able to draw a blood sample for genetic testing on the day of your initial visit and ask the lab to hold the sample until prior authorization is obtained.

Can my employer or health insurance use my genetic test result against me?
In 2008 a federal law known as the Genetic Information Nondiscrimination Act (GINA) was passed to prohibit discrimination based on genetic information by employers and health insurance companies. For more information, please see www.dnapolicy.org/gina. Our genetic counselor will also be able to discuss this issue with you further during your visit.

Can I have genetic testing without formal genetic counseling?
No. We do not offer genetic testing without genetic counseling because it is important to review your complete medical and family history. There are many types of genetic risk factors for cancer and it is in your best interests to have a complete assessment by an expert in cancer genetics to make sure the most appropriate tests are ordered. In addition, we spend time discussing the benefits and limitations of genetic testing along with providing result interpretation and medical management.

If I come in for an appointment am I required to have genetic testing?
No. During your appointment we may discuss the option of genetic testing but it is your choice to proceed, not proceed, or wait to test.

Pre-Visit Questionnaire
Hereditary Cancer Risk Assessment

Instructions:

1. If you received this questionnaire via e-mail or online, you can type your answers directly into the form via Adobe Reader and save it. This will enable you to e-mail it back to us directly. **Please also save a copy for your records.**

For Mac Users: If you type your answers directly into the form, you will need to make sure you use Adobe Reader and NOT the default PDF reader Mac computers use. If you use the default Mac PDF file reader, your form will be blank when opened on our PCs.

2. Please complete the following questionnaire to the best of your ability. It may be helpful to speak with other family members in order to obtain more accurate information. The more accurate your information, the better our assessment will be. If you are unsure of certain information or do not have certain information, please make your best guess or write "unknown."

3. Once complete, please send a copy of the completed questionnaire back to us either via e-mail, fax, or mail. **IF MAILING, PLEASE DO NOT SEND THIS PAPERWORK BACK TO US DOUBLE-SIDED.** Please see page 1 for contact information. Note: you only need to send back the questionnaire (pages 4-17).

If You or a Family Member Had Genetic Testing Already:

If you or another family member had genetic testing already, please include a copy of the genetic test results for review. We will need this information if you want to be tested for a certain genetic risk factor found in another family member.

Part A: Basic Information

Last Name: _____ First Name: _____ Middle Initial: _____

Maiden Name: _____ Suffix: _____ Preferred Name: _____

Date of Birth: _____ Current Age: _____ Gender: _____

Ethnicity: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____

Employment Information:

☐ Not Employed ☐ Employed ☐ Full-time ☐ Part-time

Employer: _____ Occupation: _____

Employer's Address: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Other: _____

How May We Contact You?

Check all that apply: ☐ Phone ☐ E-Mail ☐ Mail

What Phone Numbers May We Use? : ☐ Home ☐ Work ☐ Cell

If you are not present to receive a telephone call, may we leave a voice-mail message? ☐ Yes ☐ No

May we leave a detailed message with someone else? ☐ Yes ☐ No

If yes, whom? _____ Relationship to You? _____

Other comments:

_____

Patient's Name: _____ Patient's Date of Birth: _____

Insurance Information

Primary Insurance:

Insurance Name: _____

Policy Number: _____ Group ID: _____

Claim's Address: _____

City _____ State _____ Zip Code _____

Inusrance Phone Number: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Subscriber's Employer: _____

Employer's Address: _____

Secondary Insurance:

Insurance Name: _____

Policy Number: _____ Group ID: _____

Claim's Address: _____

City _____ State _____ Zip Code _____

Inusrance Phone Number: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN: _____

Subscriber's Employer: _____

Employer's Address: _____

Patient's Name: _____

Were you referred by a specific physician? If yes, please provide his or her name and speciality below:

_____

If you were not referred by a specific physician, how did you hear about us?

What is the reason for the appointment? Do you have any specific concerns or questions?

Have YOU ever had genetic testing (related to cancer)? ☐ Yes ☐ No

If yes, what was the test? and what were the results?

Important: **Please include a copy of your genetic test results with your completed questionnaire.**

Part B: Cancer History

If you have been diagnosed with cancer, please provide history below:

Age at Diagnosis	Cancer Location & Type (First place in the body where the cancer started, not where it spread)	What Was Your Treatment? (For example: surgery type, chemotherapy, radiation therapy, and/or hormonal therapy)

Patient's Name: _____

Part C: Medical History

Medical Diagnoses, Conditions or Illnesses:

Surgical History:

Known Allergies and Reactions:

Lifestyle Information:

☐ Yes ☐ No **I use or have have used tobacco**

If yes, what type (cigarettes, pipe, etc), at what ages, and how much a day? _____

☐ Yes ☐ No **I drink alcohol**

If yes, how much and how often? _____

Women Only:

Age at first period?: _____ Age when you had your first child? _____

☐ Yes ☐ No **I have used birth control pills**

If yes, at what ages and for how long? _____

☐ Yes ☐ No **I have experienced menopause** Age at menopause? _____

Cause of your menopause? ☐ Natural ☐ Chemotherapy ☐ Radiation ☐ Surgery

☐ Yes ☐ No **I have used hormone replacement therapy (ex: estrogen, progesterone)**

If yes, what type and for how long? _____

If you have NEVER had breast cancer, how many breast biopsies have you had? _____

Did any of the biopsies show atypical hyperplasia? ☐ Yes ☐ No ☐ Unknown

Did any of the biopsies show LCIS? ☐ Yes ☐ No ☐ Unknown

Patient's Name: _____

For Men & Women:

☐ Yes ☐ No **I have a history of colon or rectal polyps**

If yes, how many? _____ How old were you when your first polyp was found? _____

Type of polyp(s)? ☐ Adenomas (pre-cancerous) ☐ Hyperplastic ☐ Juvenile ☐ Unknown

☐ Yes ☐ No **I have a history of a birth defect, genetic disorder, or other inherited condition**

If yes, please describe: _____

Part D: Cancer Screening History

Women:

☐ Yes ☐ No **I examine my breasts for suspicious lumps or changes every month**

Comments: _____

☐ Yes ☐ No **I have regular breast exams by a health care provider**

If yes, how often? _____

☐ Yes ☐ No **I have mammograms every year**

Comments: _____

☐ Yes ☐ No **I have breast MRIs every year**

Comments: _____

☐ Yes ☐ No **I have regular pelvic exams and PAP smears**

If yes, how often? _____

Men:

☐ Yes ☐ No **I have digital rectal exams every year to screen for prostate cancer**

Comments: _____

☐ Yes ☐ No **I have a PSA blood test every year to screen for prostate cancer**

Comments: _____

Men & Women:

☐ Yes ☐ No **I have regular colonoscopies**

If yes, how often? _____ Last colonoscopy? _____

Comments: _____

Please describe any other cancer screening you receive:

Patient's Name: _____ Patient's Date of Birth: _____

CURRENT MEDICATIONS

Date Completed: _____

Please list all prescription and non-prescription medications and supplements. Please provide dosage and frequency of use (for example: 10mg once a day OR 10mg three times a day)

MEDICATION	DOSE	FREQUENCY	REASON FOR MEDICATION	ROUTE (mouth, injections, eye drops, etc)

Patient's Name: _____

Part E: Family History

☐ I am adopted and know nothing about my biological family history (you are finished with the questionnaire)

☐ I am adopted but know *some* information about my biological family history (please see questions below)

1) Has anyone in your family ever had genetic testing? ☐ Yes ☐ No

If yes, who? what was the test? and what were the results?

Important: **Please include a copy of any family members' genetic test results with your completed questionnaire.** If you are being tested for a genetic mutation found in another family member, it is important to have a copy of this family member's test result. Knowing the specific mutation enables us to offer a more targeted and affordable test to you.

2) Has anyone in your family been diagnosed with a genetic condition? ☐ Yes ☐ No

If yes, who and what was the diagnosis?

3) Has anyone in your family been diagnosed with multiple colon or stomach polyps? If so, please specify who and how many polyps:

4) What is your ancestry?

a) What countries are your maternal ancestors originally from? _____

b) What countries are your paternal ancestors originally from? _____

c) Is your mother of Ashkenazi Jewish descent? ☐ Yes ☐ No ☐ Unknown

d) Is your father of Ashkenazi Jewish descent? ☐ Yes ☐ No ☐ Unknown

Instructions for Completing the Family History Tables (starting on the next page):

1) Please make sure you include both family members who have a history of cancer, along with those without a history of cancer.

2) For those family members with a history of cancer, it is very important to provide his/her age of diagnosis (if you are unsure of the age of diagnosis, please provide your best guess).

Patient's Name: _____

Please provide the following information about each individual:

1) First Name
2) Alive or deceased? If deceased, cause of death?
3) If alive, please provide his/her current age. If deceased, please provide age at death.
4) Any cancer history. Please include type of cancer and age of diagnosis. If the individual had more than one cancer, please list each type and age of diagnosis for each cancer.
5) Any other pertinent information

Example:

1) Mary
2) Deceased, died from ovarian cancer
3) Died at age 58
4) Breast cancer at age 49, Ovarian cancer at age 57
5) She was a lifelong smoker

Your Mother:

Your Father:

Please provide the following information about each individual:

1) First Name
2) Alive or deceased? If deceased, cause of death?
3) If alive, please provide his/her current age. If deceased, please provide age at death.
4) Any cancer history. Please include type of cancer and age of diagnosis. If the individual had more than one cancer, please list each type and age of diagnosis for each cancer.
5) Any other pertinent information

Your Mother's Mother (Maternal Grandmother):

Your Mother's Father (Maternal Grandfather):

Your Father's Mother (Paternal Grandmother):

Your Father's Father (Paternal Grandfather):

Patient's Name: _____

Please provide the following information about each individual:

1) First Name
2) Gender (male or female)
3) Alive or deceased? If deceased, cause of death?
4) If alive, please provide his/her current age. If deceased, please provide age at death.
5) Any cancer history. Please include type of cancer and age of diagnosis. If the individual had more than one cancer, please list each type and age of diagnosis for each cancer.
6) Number, age, and sex of children. If any of his/her children has a history of cancer, please include information for above items 1-5 for each child with a history of cancer.

Example:

1) Taylor: Male, Alive, 30 years old, no cancer. His daughter Mary, died from leukemia at age 5 she was diagnosed at age 5.

Your Biological Children: (List all)

Patient's Name: _____

Please provide the following information about each individual:

1) First Name
2) Gender (male or female)
3) Alive or deceased? If deceased, cause of death?
4) If alive, please provide his/her current age. If deceased, please provide age at death.
5) Any cancer history. Please include type of cancer and age of diagnosis. If the individual had more than one cancer, please list each type and age of diagnosis for each cancer.
6) Number, age, and sex of children. If any of his/her children has a history of cancer, please include information for above items 1-5 for each child with a history of cancer.

Please note if any siblings are adopted, half-siblings, step-siblings, or twins (identical vs. non-identical). If half-siblings, please note if you share the same mother or father.

Your Sisters & Brothers: (List all)

Patient's Name: _____

Please provide the following information about each individual:

1) First Name
2) Gender (male or female)
3) Alive or deceased? If deceased, cause of death?
4) If alive, please provide his/her current age. If deceased, please provide age at death.
5) Any cancer history. Please include type of cancer and age of diagnosis. If the individual had more than one cancer, please list each type and age of diagnosis for each cancer.
6) Number, age, and sex of children. If any of his/her children has a history of cancer, please include information for above items 1-5 for each child with a history of cancer.

Please note if any aunts or uncles are adopted, half-siblings to your mother, step-siblings to your mother, or twins (identical vs. non-identical). If half-siblings, please note if they share the same mother or father with your mother.

Your Maternal Aunts and Uncles (Your Mother's Sisters and Brothers): List all

Patient's Name: _____

Please provide the following information about each individual:

1) First Name
2) Gender (male or female)
3) Alive or deceased? If deceased, cause of death?
4) If alive, please provide his/her current age. If deceased, please provide age at death.
5) Any cancer history. Please include type of cancer and age of diagnosis. If the individual had more than one cancer, please list each type and age of diagnosis for each cancer.
6) Number, age, and sex of children. If any of his/her children has a history of cancer, please include information for above items 1-5 for each child with a history of cancer.

Please note if any aunts or uncles are adopted, half-siblings, step-siblings, or twins (identical vs. non-identical). If half-siblings, please note if they share the same mother or father with your father.

Your Paternal Aunts and Uncles (Your Father's Sisters and Brothers): List all

Patient's Name: _____

Other Family Members Not Already Listed:

Please provide the following information about each individual:

1) Relation to you (please be very specific and describe through which individuals this person is related to you)
2) Gender (male or female)
3) Alive or deceased? If deceased, cause of death?
4) If alive, please provide his/her current age. If deceased, please provide age at death.
5) Any cancer history. Please include type of cancer and age of diagnosis. If the individual had more than one cancer, please list each type and age of diagnosis for each cancer.
6) Number, age, and sex of children. If any of his/her children has a history of cancer, please include information for above items 1-5 for each child with a history of cancer.

Examples:

1) My maternal grandmother's sister, died from breast cancer in her 60s, age of diagnosis unknown. Her daughter also was diagnosed with breast cancer, she is deceased, we do not know her age of diagnosis.

Other Comments/Additional Information: