Breast Imaging Center
Lakeside Professional Park
195 Parrish Street, Suite 103
Canandaigua, NY 14424

RISK ASSESSMENT FOR HEREDITARY CANCER

Name:_____ Date Completed:_____

Primary Physician:_____ Date of Birth: _____

The Center for Breast Health is committed to providing you with the highest level of quality care. This Risk Assessment for Hereditary Cancer Syndromes identifies patients at high or elevated risk for **specific genetic cancers** so that appropriate screenings can be made available. Your personal and family history of cancer will be evaluated as part of your imaging to provide you with the most optimal care.

If it appears you are at an elevated risk, we are required to provide you with patient education as part of your imaging today. Please be as thorough and accurate as possible.

1.) Have you ever been diagnosed with any of the following cancers? (Circle all that apply) No

Breast Ovarian Colorectal Uterine Prostate Pancreatic Gastric Melanoma

Age at time of your diagnosis: _____

2.) Has anyone in your family (blood relative) ever been diagnosed with any of the following cancers? (Circle all that apply)
Consider the following family members: *Mother, Father, Siblings, Children, Half-Siblings, Aunts/Uncles, Grandparents, Nieces/Nephews, Great Aunts/Uncles, Great Grandparents, First Cousins*

Breast Who: _____ Age at time of diagnosis: _____

Ovarian Who: _____ Age at time of diagnosis: _____

Colorectal Who: _____ Age at time of diagnosis: _____

Uterine Who: _____ Age at time of diagnosis: _____

Prostate Who: _____ Age at time of diagnosis: _____

Pancreatic Who: _____ Age at time of diagnosis: _____

Gastric Who: _____ Age at time of diagnosis: _____

Melanoma Who: _____ Age at time of diagnosis: _____

Criteria: 3 or more cancers on the **same side of the family**, young cancer (under 50) in a first degree relative (parent, grandparent, sibling), or rare cancers (male breast, ovarian or pancreatic cancer).

3.) Have you or a family member ever been tested for hereditary cancer (e.g. BRCA, Lynch Syndrome)? Yes No
If yes: Who:_____ Year tested: _____ Result?_____

Insurance coverage for genetic testing varies based on each individual insurance company and personal/family risk factors. Medicare coverage only applies for those with a personal history of cancer.

To the best of my knowledge, I have provided the most accurate answers to the above questions.

Patient Signature: _____ Patient declined video/education **(initials)**_____

FOR OFFICE USE ONLY:

Reviewer Initials: _____

Patient watched video: Yes No If no, reason?_____
Educational material given: Yes No If no, reason?_____
Patient spoke with GC: Yes No If no, reason?_____
Patient tested with myRisk: Yes No If no, reason?_____

Aetna EX/Blue MVP UHC Medicare Medicaid CSP VA Other: _____
Notes: