

# Breast Screening Mammogram

FOR HCP and LEAF

Please check the appropriate 1) Risk Detail AND 2) Risk Factor (if applicable) in the checkboxes provided.

Risk Factor	Risk Detail
<p>Known pathogenic gene variant carrier.</p> <p>Untested family member of a known pathogenic gene variant carrier.</p>	<p>BRCA1</p> <p>BRCA2</p> <p>ATM</p> <p>CDH1</p> <p>CHEK2</p> <p>NBN</p> <p>NF1: only high-risk 30-50 yo</p> <p>PALB2</p> <p>PTEN: Cowden Syndrome</p> <p>STK11</p> <p>TP53: Li Fraumeni Syndrome</p> <p>RAD51D</p> <p>RAD51C</p> <p>BARD1</p> <p>OTHER: _____</p>
<p>Thoracic radiation: _____</p>	
<p>Systemic treatment: _____</p>	
<p>Other: _____</p>	

Please complete ALL fields and fax form to BC Cancer Screening Programs Client Services at: 604-877-6113.

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient PHN: \_\_\_\_\_

## Health Care Provider Information

Name: \_\_\_\_\_ MSP #: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Notes: \_\_\_\_\_

## For Client Services Centre use only:

Appointment Date & Time: \_\_\_\_\_

Screening Centre: \_\_\_\_\_

Referral on file

CC: HCP (results)

CC: LEAF (results)