Risk Assessment for Myriad myRisk® Hereditary Cancer Testing

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please indicate those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side).

CANCER DIAGNOSIS	RELATIONSHIP (Parents, Siblings, Children, Aunts/Uncles, Grandparents, First Cousins, Nieces/Nephews	SPECIFICS
☐ Metastatic prostate cancer		Gleason(s): Age(s) of Diagnosis:
☐ Prostate cancer with a Gleason score ≥7 **and** a family member with metastatic prostate cancer		Gleason(s): Age(s) of Diagnosis:
☐ Prostate cancer with a Gleason score ≥7 **and** a family member with breast cancer ≤50 years of age		Gleason(s): Age(s) of Diagnosis:
☐ Prostate cancer with a Gleason score ≥7 **and** a family member with ovarian cancer at any age		Gleason(s): Age(s) of Diagnosis:
☐ Prostate cancer with a Gleason score ≥7 **and** a family member with pancreatic cancer at any age		Gleason(s): Age(s) of Diagnosis:
☐ Prostate cancer with Gleason score ≥7 **and** at least two family members (on the same side of the family) with breast or prostate cancers (Gleason score ≥7) at any age		Gleason(s): Age(s) of Diagnosis:
☐ Prostate cancer with a Gleason score ≥7 **and** Ashkenazi Jewish ancestry		Gleason(s): Age(s) of Diagnosis:
Other cancer family history:		Age(s) of Diagnosis:

☐ You or someone in your family has had genetic testing for a hereditary cancer syndrome.

Explain: _____

_____
Patient's Signature Date

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☐ Candidate for further risk assessment and/or Myriad myRisk® testing ☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: _____

☐ Patient offered Myriad myRisk® testing: ☐ Accepted ☐ Declined

_____
Healthcare Professional's Signature Date

Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.MyriadPro.com/guidelines.

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