

This letter includes instructions for your appointment for genetic counseling with the Cancer Genetics Program at Virtua Fox Chase Cancer Program. Please read this letter upon receipt so you are prepared for your first visit.

Sincerely,
Bridget LeGrazie, RN, MSN, APN,c., AOCN, APNG
Janice Christiansen, MS, CGC
Dana Falcone, MS, CGC
Virtua Fox Chase Cancer Genetics Program
Center for Health and Wellness
200 Bowman Drive, Ste D290
Voorhees, NJ 08043
Phone: 856-247-7373

PRIOR TO YOU SCHEDULED APPOINTMENT:

- □ Please complete the enclosed forms and send them back to us prior to your appointment. If you bring the completed forms the day of your visit or if you need to complete the forms when you arrive for your visit, your appointment will take longer than expected or may need to be rescheduled:
 - **a.** Family history forms: Please complete all sections as best you can. Include all family members, including family members not affected with cancer.
 - b. Medical history forms
 - c. Form 1: Complete and list any physicians whom you would like us to send a report to, regarding your appointments with the Cancer Genetics Program.
 - d. Form 2: This form is used to give permission for us to answer any questions family members may have about your genetics visit. We will not directly contact these family members.
 - e. Include a copy of *your* pathology records or other documentation of your cancer or your non-cancer biopsies (if applicable). If possible, include reports for the cancers in *your family members*. If you are coming for an appointment related to colon polyps in yourself or your family members, please have your colonoscopy reports and pathology reports of the polyps sent to us.
 - i. You will need to call your doctor and request the records be sent to us. Just because you were seen by a Virtua doctor, does not mean we have access to them.
 - f. If any family members had **genetic testing related to cancer**, please include a copy of their test results or bring them with you to your appointment.
- Once your forms are completed and you have collected the necessary records, please send them to us via:
 - a. Mail: to allow for postal mail delivery in time for your appointment, return them 10 days prior to you appointment in the enclosed self addressed stamped envelope (we recommend making yourself a copy first)

b. Fax: 856-247-7400c. Email: cgp@virtua.org



ON THE DAY OF YOUR VISIT (Directions attached):

- □ Bring a copy of the paperwork that you either mailed/emailed/faxed to us.
- □ Report to Outpatient Registration in suite E250:
 - i. Please bring with you: identification, your insurance cards, a copy of/or confirmation number for your referral or authorization (if required by your insurance) and the amount you are responsible to pay for the visit.
 - ii. Referrals should be made out to Virtua Voorhees (Tax ID# 210634532) for 3 visits for genetic counseling (CPT Code 96040)
- Once you are registered in Suite E250, you will report to Suite D290 for your appointment.
- □ Please allow 2 hours for your appointment.
- As a courtesy to other patients and our counselors, please give us 48 hours advance notice of cancellation.

OUESTIONS ABOUT INSURANCE COVERAGE FOR GENETIC COUNSELING:

- ☐ Mariann Heuser, a Registrar from Virtua, will contact your insurance for you to determine your coverage for genetic counseling and what responsibility you have for the visit. She will contact you if you do not have coverage for the visit. If you have questions regarding your coverage or about referrals or authorizations, Mariann can be contacted at 609-914-6303. This does not include costs for genetic testing. Your eligibility, the costs and preauthorization for testing will be discussed at the time of your first visit.
- If you do not have insurance coverage for the visit, you can expect the total cost for your genetic counseling to be approximately \$450.00. This does not include genetic testing costs. It is possible to have coverage for genetic testing even if genetic counseling is not a covered service. The costs and preauthorization for testing will be discussed at the time of your first visit.

SPECIAL NOTE:

You may see one of our physicians at the time of your follow-up visit. If you see a physician, you are responsible for any co-pay or coinsurance that you typically would pay to see a specialist. The physicians are Noah Lindenberg NPI# 1346311073 and Priya Gor NPI #1710915269. They bill separately from Virtua's Cancer Genetics Program. We encourage you to check with your insurance carrier to determine if these physicians participate with your insurance plan.

Family History of Cancer
Part 1 – You, Your Parents (Blood relatives only) and Your Spouse(s)

Please print all information

		Y N ?	Alive			
			/ /		Parent of your children, if other than #4 or #5.	က
			Alive			
		6 N A	/ /		than your current spouse	۶
	-	· Y N ?	Alive 🗌			7
	-	l	, ,		4. Cuitetti spouse	‡.
		- 'Y	Alive 🗌			
			/ /		3. Your father	ယ
		イ Z ?	Alive			
		, see	1.1		2. Your mother	5
		\ Z ?	Alive 🗌			
			1 1		1. Yourself	
42 yr. old	Skin	Not sure = ?	Mo/Day/Yr	Mo/Day/Yr		
Example	Breast Colon	Xes ⊥X	Example: / (1994)	Example: (1924)		
Found	Examples:	Circle	year and circle.	year and circle.		
When	Cancer	©ancer	If you are not sure	If you are not sure of date estimate	(no nicknames)	(
Age	Type of	Has had	Date of Death	Date of Birth	First & last name	<u> </u>

3/2006

Family History of Cancer Part 2 –Your Grandparents (Blood relatives only)

Please print all information

T T	First & last name (no nicknames) 7. Your mother's mother 8. Your mother's father 9. Your father's mother	Date of Birth If you are not sure of date, estimate year and circle. Example: (1924) Mo/Day/Yr	Date of Death If you are not sure of date, estimate year and circle. Example: //(1994) Mo/Day/Yr /// Alive Alive Alive Alive Alive Alive Alive Alive		Type of Cancer Examples: Breast Colon Skin
Your father's father Alive			/ / Alive []	≺ Z	
			/ / Alive		
			·		

Family History of Cancer Part 3 –Your Brothers and Sisters (Blood relatives only)

☐ Check here if you have no blood brothers or sisters and go to next page Do you have the same mother as your brothers and sisters? ☐ Yes ☐ No Do you have the same father as your brothers and sisters? ☐ Yes ☐ No

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16.	15	14	13	12.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	First & last name (No nicknames) Please print all information
B	B S	S B	ω B	BS	B 0	Circle Brother (B) Sister (S) Example: B (S)
						Date of Birth If you are not sure of date, estimate year and circle Example 1924 Mo/Day/Yr
Alive	Alive	/ / Alive □	/ / Alive 🔲	/ / Alive	/ / Alive	Date of Death If you are not sure of date, estimate year and circle Example: / / 1994 Mo/Day/Yr
; N Å	Y N ?	, N δ.	Y N ?	イ ス ?	Y Z ?	Has had Cancer Circle Yes = (Y) No = N Not sure = ?
		- Christian and American				Type of Cancer Examples: Breast Colon Skin
						Age When Cancer Found Example 42 yr. old
						H HM

Family History of Cancer Part 4 – Your Children

☐ Check here if you have no biological children and go to next page Do all your children have the same mother and father? ☐ Yes ☐ No If no, list parent on page 4, lines #5 and #6.

			<u>-,</u>	 			
22.	21.	20.	19.	18.	17.	ase print all information	First & last name (No nicknames)
S D	S D	S D	S D	S D	S D	Example:	Circle Son (S) Daughter (D)
						Mo/Day/Yr	Date of Birth If you are not sure of date, estimate year and circle
/ / Alive	Alive	/ / Alive	/ / Alive	/ / Alive	/ / Alive	Example: / <u>K.1994</u> Mo/Day/Yr	Date of Death If you are not sure of date, estimate year and circle
Υ N ?	Υ N ?	Y N ?	Y N ?	Y N ?	Y N ?	Yes = (Y) No = N Not sure = ?	Has had Cancer
						Breast Colon Skin	Type of Cancer
						Example 42 yr. old	Age When Cancer
	· ·						۳ #

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Family History of Cancer Part 5 -Your Mother's Brothers and Sisters

☐ Check here if your mother had no blood brothers or sisters and go to next page Do all of your aunts and uncles on your mother's side have the same mother? ☐ Yes ☐ No Do all of your aunts and uncles on your mother's side have the same father? ☐ Yes ☐ No

	28.	27.				23.	First & last name (No nicknames) Please print all information Example: Brother (B) Sister (S) Example: Mo/Day/Yr Date of Birth If you are not sure of date, estimate year and circle Example: Mo/Day/Yr Date of Birth If you are not sure of date, estimate year and circle Example: / 1924
B S		B S	BS	S	BS	BS	Circle Brother (B) Sister (S) Example: B (S)
		-	-	`			Date of Birth If you are not sure of date, estimate year and circle Example (1924) Mo/Day/Yr
Alive		/ / Alive □	/ / Alive 🔲	/ / Alive	/ / Alive □	/ / Alive	
Y N ?	7	√ ′ ∠ ∨	, N 5	Υ N ?	Y N ;	Y N ?	Has had Cancer Circle Yes = V No = N Not sure = ?
							Type of Cancer Examples: Breast Colon Skin
	•			,			Age When Cancer Found Example 42 yr. old
							HM HR

Part 6 - Your Father's Brothers and Sisters **Family History of Cancer**

☐ Check here if your father had no blood brothers or sisters and go to next page

Do all of your aunts and uncles on your father's side have the same mother? ☐ Yes ☐ No

Do all of your aunts and uncles on your father's side have the same father? ☐ Yes ☐ No

First & last name		Yes
		es on your tati
Date of Rinth		her's side have the
Data of Doath		ne same father?
	-	☐ Yes ☐ No
	Use Only	Office

	34	33.	32.	3.	30.	29.		Please print all information	(No nicknames)
в «	B	α «		B S	. S	o o	8 (6)	. Example:	Circle Brother (B) Sister (S)
							Mo/Day/Yr	year and circle Example 1924	Date of Birth If you are not sure of date, estimate
Alive	Alive	Alive 🗆	/ /	Alive	/ / Alive	Alive	Mo/Day/Yr	year and circle Example: / (1994)	Date of Death If you are not sure of date, estimate
≺ N ?	Y. N ?	≺ N ?		У N э	У N ;	, N 5	No = N Not sure = ?	Circle Yes ≠ Y	Has had Cancer
,							Colon Skin	Examples: Breast	Type of Cancer
							Example 42 yr. old	Found	Age When
				,					H HA

Family History of Cancer Part 7 –Additional Family Members with Cancer

• Please use this page to add any additional blood relatives such as first cousins, grandchildren, nieces or nephews, who have had cancer. Please indicate the parent number of each relative (from previous pages). For example, #35 cousin, Jane is daughter of #29, who is your father's sibling.

								
40.	39.	38.	37.	36.	35. Jane Douglas		Please print all information	(No nicknames)
MF	M T	M	<u>м</u>	M	≤ (∓)	Example:	Female (F)	Circle Male (M)
					2/12/1921	Mo/Day/Yr	year and circle Example: 1924	If you are not sure of date, estimate
<u>^</u>	/ / Alive	Alive	Alive	Alive	/ (1970) Alive	Mo/Day/Yr	year and circle Example: / (1994)	Date of Death If you are not sure of date, estimate
≺ Z .>	≺ ' Z ?	Y N ?	, N	Y N ?	(N)	No = N Not sure = ?	Circle Yes (Y)	Has had Cancer
٠.					Breast	Colon	Examples:	Type of Cancer
	-				4	Example 42 yr. old	Cancer Found	Age When
			-		#29		From previous page	Parent #

PATIENT NAME:

Personal Medical History		lVirtua Nor	th
Virtua Fox Chase: Cancer Genetics Program		IVirtua Sou	th
This form will provide us with important inform Please fill in the blanks and boxes.	nation about your	health.	
Today's Date:	Date of Birth:	Age:	□ Male □ Female
Name: Who referred you?	Date of birth.	Age.	Li Plate Li Terrigio
Who is your: Medical Oncologist:	Gynecologist:		
Primary Care Doctor:	Oncologist:		•
Breast or GI Surgeon:	Gastroenterol	naist:	
Nurse Navigator:	Social Worker		
We would like to add you to our email list to redesigned for you to receive annual genetics up address here: What is your primary reason for coming to the	dates from Virtua	. Please writ	
Are you interested in knowing your eligibility to List any concerns or issues you would like to sp			
Are you, your parents or grandparents of Jewish deceder Has anyone in your family ever had cancer genetic test? Do you have a copy of results? Name of genetic test? Do you ever had cancer genetic testing? No Yes Name of genetic test? Do you have a copy of results? No Yes Name of genetic test? Do you have a copy of results? No Yes If What is/was your usual occupation? Do you exercise? No Yes If yes, how many minuses If yes, list amount: Po you smoke now? No Yes If yes, list amount: Packs per day, and how Did you smoke in the past? No Yes If yes, list amount: No Yes If yes, list No Yes If Yes If	Result of general Result of general Result of general Result of general Result of genetic Result of genetic for any our obtain tes per week?: Yes If yes, when? The many years: The many years:	tic test? a copy? □No [test? a copy? □No [Wh]Yes
1,555 1.00 1.10 1.10 1.10 1.10 1.10 1.10 1			
List all medication allergies:			

Cancer Screening History:
Have you had colon screening with colonoscopy? □No □Yes
If yes, list year of last screening:
Have you had colon screening with sigmoidoscopy? □No □Yes
If yes, list year of last screening:
Have you had colon polyps? □No □Yes Age at first polyp:
How many polyps (total) have you ever had? 1 2 3 4 5 6-15 16-50 50-100 >100
Have you had a skin screening exam? □No □Yes If yes, list year of last screening:
Have you ever had skin cancer? □No □Yes If yes, what type? At what age?
For Males:
Have you had prostate screening with: PSA? □No □Yes Digital Rectal Exam? □No □Yes
**Males go to page 3
For Females:
Do you perform breast-self exam? □No □Yes How often? □ Monthly Other:
Do you have regular breast exams by a doctor? No Yes When was your last breast exam?
How often does your doctor do your breast exam? □ yearly □ other:
Have you ever had a mammogram? □No □Yes Approximate date of your last mammogram:
Age at first mammogram: How often do you have mammograms? yearly other:
Have you ever had a breast MRI? □No □Yes □ Unsure
Approximate date of your last breast MRI:
How often do you have breast MRI? □ yearly □ other:
When was your last pelvic exam?
How often do you have pelvic exams? ☐ yearly ☐ other:
Have you ever had an abnormal Pap smear? □No □Yes
Have you ever had a transvaginal ultrasound? □No □Yes □Unsure Why?
How often do you have transvaginal ultrasound? □ yearly □ other:
Have you ever had a CA125 (a blood test to screen for ovarian cancer)? □No □Yes □Unsure
How often do you have CA125? ☐ yearly ☐ other:
Gynecological: For Female Patients to Answer
At what age did you start your menstrual periods? Are you still having menstrual periods? Yes No If no, at what age did they end?
Are you still having menstrual periods? Yes No If no, at what age did they end? Why did your periods stop?
Have you had your ovaries surgically removed? No Yes If yes, when? Why?
Have you had your uterus surgically removed? No Yes If yes, when? Why?
Have you ever been pregnant? No Yes
How many times have you been pregnant?
Number of live births: Number of Miscarriages/Terminations:
How old were you when you gave birth to your first child?
Did you breastfeed? No Yes How long?
Do you have a history of fertility medication use? No Yes If yes, type: # of cycles:
Have you taken hormone replacement therapy (HRT)? No Yes If yes, for how long?
Have you ever taken oral contraceptives? No Yes If yes, for how long?
Have you taken Tamoxifen? No Yes If yes, for how long?
Have you ever taken Raloxifene (Evista)? No Yes If yes, for how long?
Have you had breast biopsies? No Yes If yes, list number:
Did any show "atypical hyperplasia (ADH)"? No Yes Unsure
Did any show "LCIS"? No Yes Unsure
Did your mother ever take DES (diethyl stilbesterol) No Yes Unsure

PATIENT NAME:

Have you ever been diagnosed with cancer? \square Yes \square No If yes, please complete this page.

Cancer Site/Type (ex. Breast, colon, ovary, etc.):	Your First Cancer:	Your Second Cancer:
Laterality (Left/Right/Not Applicable)		
Date of Diagnosis		
Age of Diagnosis		
Did you have Surgery for this Cancer?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
If yes: Name of Procedure		
Surgery Date		
Treatment Hospital		
Did you receive Chemotherapy for this Cancer?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
Date Chemo started		
Treatment Hospital		
Did you receive Radiation for this Cancer?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
Date Radiation started		
Treatment Hospital		
Did you receive Hormonal Therapy for this Cancer?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
If yes: Name of Hormone (ex. Tamoxifen, Aromasin, Femara)		
Treatment Hospital		
Date Hormonal Therapy started		
Did you receive any other type(s) of therapy?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
If yes: Please specify.		
Date Other Therapy started		
Treatment Hospital		
Have you had a Recurrence with this Cancer?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
If yes: Date of Recurrence?		
Where did this cancer recur? (ex. lung, breast, liver)		
Treatment Hospital		

PATIENT NAME:

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	re there any medical probe e medication for? □No □\		es) for which you have received
Problem	Treatment		Age At Diagnosis
Surgical History:	Have you ever had any sur	geries? □No □Yes If ye	es, please list:
Type of	Reason/	Hospital /	Date
surgery	Diagnosis	Doctor	(year)
1.004			

Other Health Problems
Please check all that apply.

Medical Condition	Never had this condition	Had it more than 12 months ago	Had it within past 12 months
Arthritis/Rheumatism			
Blood Clots (lungs, legs)			
Colitis (inflammatory bowel, Crohn's)			
Diabetes			
Endometriosis			
Heart Problems			
High Blood Pressure			
Kidney Problems			
Osteoporosis/Osteopenia (bone loss, thinning)			
Ovarian Cyst			
Stroke			
Fibrocystic breasts			
Uterine Fibroids			
Lipoma			
Skin abnormalities			
Thyroid Disease or nodules			

FORM 1

Virtua Fox Chase Cancer Genetics Program

Note to Recipient of Information: When applicable this information has been disclosed to you from records whose confidentiality is protected by Federal Law, including but not limited to, (42 CFR-Part 2) and/or New Jersey Administrative Statutes, including but not limited to, (NJSA 26:5C-6). These regulations in part prohibit you from any further disclosure of this information without the specific written consent of the person to whom the records pertain, or as otherwise permitted by such regulation. The Federal Regulations restrict any use of the information for criminal investigation or prosecution. A GENERAL Authorization for the release of records protected by these regulations is not sufficient for this purpose.

Purpose/Need	d for Disclosur	e: Medical Follow-Up	
PATIENT NAME (first	, middle, last)	DATE OF BIRTH	TELEPHONE NUMBER (including area code)
ADDRESS (number, s	street, city, state, zip)		SOCIAL SECURITY NUMBER
TYPE OF VISIT an TREATMENT DAT	*-	Cancer Risk Counseling and Education, date (s) Other, date (s)	
SPECIFIED REPO	RTS:		
☐ Genetic	: Test Results	nmary and Recommendations Letter to Health Car	
RELEASE TO:	Person/s Name		
	Organization		<u> </u>
	Street Address		
	City/State/Zip		
RELEASE TO:	Person/s Name		
	Organization		
	Street Address		
	City/State/Zip	MATERIAL PROPERTY 1	

FORM 1

RELEASE TO:	Person/s Name Organization Street Address City/State/Zip Person/s Name Organization Street Address City/State/Zip			 - -
COMMENTS:	None			
named above informincluding: psychological	nation from my r gical or psychia	nedical records relating tric impairment; drug	to my identity, diagnosis	o disclose to that person/organizations, prognosis, treatment and conditionm; sickle cell anemia; and acquired ficiency virus (HIV).
that this consent sh	all operate as a		oility to the Virtua Health	eatment detailed above. I understand program specified above, its trustees
	ve and in that ca			nay be subject to re-disclosure by the surance Portability and Accountability
that I have a right to writing and present revocation will not a the revocation will n	o revoke this aut my written rev pply to information of apply to my in	norization at any time. ocation to the health ion that has already been surance company whe	I understand that if I revinformation management in released in response to	rms of this authorization. I understand voke this authorization I must do so in the department. I understand that the othis authorization. I understand that issurer with the right to contest a claim the date of signature.
l understand author ensure healthcare tr	_	disclosure of the inform	ation identified above is v	voluntary. I need not sign this form to
PATIENT <u>or</u> PATIENT	REPRESENTATI	VE SIGNATURE		DATE SIGNED
If Patient Representat	ive, give relationsh	ip to Patient		

FORM 2

VIRTUA

Authorization for Verbal Disclosure of Cancer Risk and Cancer Genetic Test Results

With this written authorization, I give permission to the health care providers of Virtua Fox Chase Cancer Genetics Program to provide a verbal disclosure of any results of my personal risk for carrying a cancer related gene including my genetic test results to the following person(s) upon their request. These persons may be members of my family, friends, physicians, clergy, and/or other. Below, I have included that person's name, relationship to me, and identifying information such as date of birth, address, or social security number so that their identity can be verified over the phone.

ame of Participant (print)	Signature of Participant	Date
ealth or unless otherwise specified by yo		er Genetics Frogram at Artitla
uis authorization will be considered vali	d throughout your participation in the Canc	er Canatias Program at Virtus
ame	Relationship to participant	Identifier
ame	Relationship to participant	Identifier
ıme	Relationship to participant	Identifier
ame	Relationship to participant	Identifier
ame	Relationship to participant	Identifier
nme	Relationship to participant	Identifier
nme	Relationship to participant	Identifier
ame	Relationship to participant	Identifier
ame	Relationship to participant	Identifier
me	Relationship to participant	Identifier



Directions for arrival for Cancer Genetics appointments

On the day of your Cancer Genetics appointment, you will report to Outpatient Registration located at 200 Bowman Drive, Suite E250, Voorhees, NJ 08043.

Directions:

From Points North

Take New Jersey Turnpike to Exit 4. Take Route 73 South. Stay on Route 73 South for approximately 5.7 miles. Pass the Route 73 and Kresson Road intersection. Turn right at the next traffic light onto Dutchtown Road. Turn left onto Howe Boulevard and proceed to Bowman Drive.

From Points South

Take Route 295 North to exit 34A onto Route 70 East. In 3.1 miles, take Route 73 South and proceed for 2.9 miles. Pass the Route 73 and Kresson Road intersection. Turn right at the next traffic light onto Dutchtown Road. Turn left onto Howe Boulevard and proceed to Bowman Drive.

Alternative Route from Points South

From the Atlantic City Expressway or Route 42

Take Berlin Cross Keys Road north to Route 73 North. Travel 3.4 miles and turn left at the traffic light onto Dutchtown Road. Turn left onto Howe Boulevard and proceed to Bowman Drive.

From Walt Whitman Bridge

When exiting the bridge, follow exit to Route 76 East. Proceed on Route 76 East to 295 North. Follow directions FROM POINTS SOUTH.

From Ben Franklin Bridge

Follow signs for Route 676 South, which becomes Route 76 East. Proceed on Route 76 East to Exit 295 North. Follow directions FROM POINTS SOUTH.

Bus Route

Route 451 stops at the hospital. For more information, call New Jersey Transit at (800) 772-2222.

Outpatient Registration is located adjacent to Virtua Voorhees Hospital in Area E. When you arrive on the hospital campus follow the signs to Neighborhood "E". Park in lot "E" and enter through the Main Lobby. Take the elevator to the second floor and follow the signs to Suite E250. Once you have registered, you will be directed to Suite D290 for your appointment. The Cancer Genetics Program office is located in Virtua Fox Chase Cancer Program office. If you are going to be late or are lost call us at 856-247-7373.