Patient with Cancer Predisposition Syndrome (CPS)

Patient Initials (first name, last name) |__|__|

Quarter and Year of Birth (q/yyyy) |__|/|__|__|__|__|

Sex □ male □ female

Please make sure that the consent form is signed before transmitting these data!

Date signed (dd/mm/yy) |__|__||__|__||__|__|

Referring physician name and institution I_____I

Address I_____I

Telephone and fax I_____I

Email I_____I

Diagnosis

Is a **specific** CPS suspected? □ No a CPS is suspected, but not a specific one

□ yes, specify name of CPS I_____I

Why was CPS considered, specify I_____I

Was the CPS diagnosed unexpectedly on the basis of a genetic analysis that was initiated for another purpose?

□ No

□ Yes, specify I_____I

Date of CPS diagnosis |__|__||__|__||__|__|

Date of genetic CPS diagnosis (if applicable) |__|__||__|__||__|__| Please submit original report.

Results of genetic testing, specify (provide precise molecular defect, e.g., mutation, nucleotide/ protein change)
Submit copy of report.
I_____I

Classification of pathogenic variant (if known)

□ pathogenic □ likely pathogenic □ uncertain significance □ likely benign □ benign

Malignancies

Was 1st malignancy diagnosed □ No

□ Yes, specify (histology/site) I_____I

date of malignancy diagnosis |__|__||__|__||__|__| Please submit reports (pathology to tumor genetics)

Which kind of tumor analysis is available? (e.g. whole genome sequencing)

I_____ _____I

Chemotherapy ☐ Yes ☐ No

name of treatment protocol I_____I

Radiation ☐ Yes ☐ No

Surgery ☐ Yes ☐ No

Comment: |_____|

Was 2nd malignancy diagnosed □ No

□ Yes, specify (histology/site) I_____I

date of malignancy diagnosis |__|__||__|__||__|__| Please submit reports (pathology to tumor genetics)

Which kind of tumor analysis is available? (e.g. whole genome sequencing)

I_____I

Chemotherapy ☐ Yes ☐ No

name of treatment protocol I_____I

Radiation ☐ Yes ☐ No

Surgery ☐ Yes ☐ No

Comment: |_____|

Was 3rd malignancy diagnosed □ No

□ Yes, specify (histology/site) I_____I

date of malignancy diagnosis |__|__||__|__||__|__| Please submit reports (pathology to tumor genetics)

Which kind of tumor analysis is available? (e.g. whole genome sequencing)

I_____I

Chemotherapy ☐ Yes ☐ No

name of treatment protocol I_____I

Radiation ☐ Yes ☐ No

Surgery ☐ Yes ☐ No

Comment: |_____|

Family history: **Please submit pedigree and clinic notes.**
Physical exam: **Please submit clinic notes / electronic photographs, if available.**

Surveillance

□ No

□ Yes, according to the AACR surveillance recommendations for patients with

- □ Leukemia-Predisposing Conditions
- □ DNA Repair Disorders
- □ Inherited Mismatch Repair Deficiency
- □ Li-Fraumeni Syndrome
- □ Neurofibromatosis 1
- □ Neurofibromatosis 2 and Related Disorders
- □ Rhabdoid Tumor Predisposition Syndrome
- □ Von Hippel-Lindau and Hereditary Pheochromocytoma/Paraganglioma Syndromes
- □ PTEN, DICER1, FH Related Tumor Susceptibility Syndromes
- □ RASopathies and other Rare Genetic Conditions with Increased Cancer Risk
- □ Retinoblastoma and Neuroblastoma Predisposition
- □ Inherited Gastrointestinal Cancer Syndromes
- □ Overgrowth Syndromes and Predisposition to Wilms Tumors and Hepatoblastoma
- □ Multiple Endocrine Neoplasia and Hyperparathyroid-Jaw Tumor Syndromes
- □ **Other,** specify I_____I

Please submit copies of

- Clinic notes summarizing pathologic surveillance results.
- CD with radiologic images that demonstrate a (suspected) malignancy.

Accompanying Projects

Liquid Biopsy

Informed Consent ☐ Yes ☐ No Date: I__I__II__I__II__I__I

ADDRess

Informed Consent ☐ Yes ☐ No Date: I__I__II__I__II__I__I

Referring physician name and institution I_____I

Address I_____I

Telephone and fax I_____I

email I_____I

Date I__I__II__I__II__I__I (dd/mm/yy) Signature _____