natera™ | Empower™ Hereditary cancer test

Is there cancer in your family? Learn if hereditary cancer testing is right for you.

Have **you** or **your parents, brothers/sisters or children** had any of the following? **Please check all that apply.***

- ☐ **Pancreatic cancer**
- ☐ **Metastatic (stage 4 or advanced) prostate cancer**
- ☐ **Colorectal or uterine/endometrial cancer** under age 50

Have **you** or **any close blood relatives** had any of the following? **Please check all that apply.***
(Relatives include your parents, brothers/sisters, children, uncles, aunts, grandparents, nieces, nephews, or half-siblings)

- ☐ **Breast cancer** at age 45 or younger
- ☐ **Male breast cancer**
- ☐ **Ovarian cancer**
- ☐ **Three or more** family members with the following cancers on the same side of the family: (breast and/or prostate) or (uterine/endometrial and/or colorectal)

For more information, text **EMPOWER** to **636363** or scan code

Checked any of the boxes? Hereditary cancer testing can help you understand if you or your loved ones have an increased risk for developing cancer, and improve the quality of your care. (Fill out next section*)

Patient Name _____ **Date of Birth** _____ **Age** _____

Date today _____ **Provider Name** _____ **Clinic Name** _____

Cancer Site If >1 diagnosis in same person, list ages or best estimates	YOUR age at diagnosis (leave blank if not applicable)	Blood relative's relationship to you and age at diagnosis (best age estimate ok)	Side of the Family	
			Mother's	Father's
Example: Breast Cancer	Age 42	Person: Aunt | Age(s): 62	X	☐
Breast Cancer	Age(s):	Person: | Age(s):	☐	☐
	Age(s):	Person: | Age(s):	☐	☐
	Age(s):	Person: | Age(s):	☐	☐
	Age(s):	Person: | Age(s):	☐	☐
Uterine/Endometrial Cancer	Age(s):	Person: | Age(s):	☐	☐
Colorectal Cancer	Age(s):	Person: | Age(s):	☐	☐
	Age(s):	Person: | Age(s):	☐	☐
	Age(s):	Person: | Age(s):	☐	☐
Prostate Cancer	Age(s):	Person: | Age(s): Was it metastatic? ☐ Yes ☐ No	☐	☐
Ovarian Cancer	Age(s):	Person: | Age(s):	☐	☐
Pancreatic Cancer	Age(s):	Person: | Age(s):	☐	☐

Signatures

Patient Name _____

Patient Signature _____ **Date** _____

For Office Use Only

Patient offered genetic testing: ☐ Yes ☐ No

Patient ☐ Accepted ☐ Declined Provider Initials: _____

Patient previously had genetic testing: ☐ Yes ☐ No

When/Where: _____ Provider Initials: _____

*Filling this form does not guarantee insurance coverage or account for all reasons to get hereditary cancer testing.

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