

Allison van Haastert, MD  
Jessica Goldberger, MD  
Meagan Byrne, DO



Wynd Counts, MD \* Wendy Cruz, MD

Katie Ulmer, ANP  
Migel Hadley, ANP  
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 \* (907)279-2273 Fax (907)258-7705 [www.wcakobgyn.com](http://www.wcakobgyn.com)

**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have received a copy of the:  
Patient's Printed Name

***Women's Care of Alaska's Notice of Privacy Practices***

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



Allison van Haastert, MD  
Jessica Goldberger, MD  
Meagan Byrne, DO

Wynd Counts, MD \* Wendy Cruz, MD

Katie Ulmer, ANP  
Migel Hadley, ANP  
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 \* (907)279-2273 Fax (907)258-7705 [www.wcakobgyn.com](http://www.wcakobgyn.com)

**COMPLETE ENTIRE FORM**

**PATIENT:**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
 Preferred Ph# \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Relationship Status: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Gender Identity: \_\_\_\_\_ Sexual Orientation: \_\_\_\_\_  
 (please circle) Race: *White \* Black \* Asian \* Pac. Islander/Nat. Hawaiian \* Amer. Indian/AK Native* (please circle) Ethnicity: *Latino/Hispanic \* Not Latino/Hispanic \* Other*

**IF PATIENT IS A MINOR**

Who may authorize treatment? \_\_\_\_\_ Relationship \_\_\_\_\_ Contact#: \_\_\_\_\_

**PARTNER:**

Partner Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
 Preferred Ph# \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Mailing Address SAME (or) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**INSURANCE:**

**PRIMARY INSURANCE COMPANY:**

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
 Subscriber ID# \_\_\_\_\_ Group# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Employment Status \_\_\_\_\_ Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**SECONDARY INSURANCE COMPANY:**

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_  
 Subscriber ID# \_\_\_\_\_ Group# \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Employment Status \_\_\_\_\_ Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**EMERGENCY CONTACT:**

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph# \_\_\_\_\_  
 Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ Ph# \_\_\_\_\_

**AUTHORIZATION** Please initial each line, and sign the bottom

- \_\_\_\_\_ I hereby authorize release of any information required to process insurance claims related to my medical and/or surgical care.
- \_\_\_\_\_ I authorize direct payment to the provider(s) for my medical and/or surgical care.
- \_\_\_\_\_ I understand that I am responsible to pay any non-covered charges or services.
- \_\_\_\_\_ I understand that if I am uninsured, I am responsible to pay for any services provided.
- \_\_\_\_\_ I have read and agree to the PATIENT FINANCIAL POLICY for Women's Care of Alaska.

How did you hear about our practice? \_\_\_\_\_

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



Allison van Haastert, MD  
Jessica Goldberger, MD  
Meagan Byrne, DO

Wynd Counts, MD \* Wendy Cruz, MD

Katie Ulmer, ANP  
Migel Hadley, ANP  
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 \* (907)279-2273 Fax (907)258-7705 [www.wcakobgyn.com](http://www.wcakobgyn.com)

## PROTECTED HEALTH INFORMATION (PHI) AUTHORIZATION

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_  
Month Day Year

### CHECK ALL METHODS OF COMMUNICATION, THAT YOU AUTHORIZE

YOUR CELL PHONE

Number: ( ) \_\_\_\_\_

Leave a call back number only;  
Do NOT leave a message

OK to leave detailed message  
with person or on voicemail

YOUR WORK TELEPHONE

Number: ( ) \_\_\_\_\_

Leave a call back number only;  
Do NOT leave a message

OK to leave detailed message  
with person or on voicemail

RESIDENCE TELEPHONE

Number: ( ) \_\_\_\_\_

Leave a call back number only;  
Do NOT leave a message

OK to leave detailed message  
with person or on voicemail

MY PREFERRED CONTACT NUMBER IS: ( ) \_\_\_\_\_ - \_\_\_\_\_

If you would like to authorize us to speak with another individual, such as a spouse/partner, or other relative regarding your PHI, please fill in their name, relation to you, and their contact number below. This information can be changed at any time, per your request. Examples of PHI include, but are not limited to:

**(T) Treatment**

Test results  
Prescriptions/refills

**(P) Payment**

Insurance questions/problems  
Account balance/payment options

**(O) Healthcare Operations Activities**

Messages returned, Referral options, Records Release

CIRCLE WHAT TO RELEASE:

Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
PLEASE PRINT (Relation to Pat.) (CONTACT#)

(T) (P) (O)

Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
PLEASE PRINT (Relation to Pat.) (CONTACT#)

(T) (P) (O)

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

## PATIENT PORTAL ACCESS

Our patient portal is set up through [www.myhealthrecords.com](http://www.myhealthrecords.com). The portal allows us to send you automated appointment reminders and messages. In addition, it allows you the ability to directly and securely message your provider, view your medical records, and much more. Activating your Patient Portal is simple. We will send you an email invitation, simply follow the instructions in the email to set up your Patient Portal Account.

CURRENT EMAIL ADDRESS: \_\_\_\_\_ @ \_\_\_\_\_

**(√) CHECK THE WAYS YOU WISH TO RECEIVE YOUR APPOINTMENT REMINDERS/MESSAGES?**

Voice Call     Text     Email     Do Not Contact Me for Reminders

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



Allison van Haastert, MD  
Jessica Goldberger, MD  
Meagan Byrne, DO

Wynd Counts, MD \* Wendy Cruz, MD

Katie Ulmer, ANP  
Migel Hadley, ANP  
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 \* (907)279-2273 Fax (907)258-7705 [www.wcakobgyn.com](http://www.wcakobgyn.com)

---

## CONSENT TO TREAT AND PAYMENT RESPONSIBILITY

The undersigned consents to medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. This may include, but is not limited to, laboratory procedures, ultrasounds, medical or surgical treatment, or procedures, or other services rendered to the patient under the general and special instructions of the physician or provider.

The undersigned understands that Women’s Care of Alaska (WCAK) has agreed to bill my insurance as a courtesy. In order to process such payments and obtain procedure authorizations, WCAK may disclose any or all my medical record to medical service companies, insurance companies, or workman’s compensation carriers, as necessary. The undersigned authorizes all insurance carriers, with whom I have coverage, including Medicare, Medicaid, and Tricare, to assign all payment of benefits due under the terms of my policy, to **Women’s Care of Alaska**, including any settlements or judgments for such items or services. The undersigned agrees to notify WCAK of any changes in my insurance coverage, as soon as possible, to ensure there is no delay in billing. If, for some reason, my health insurance sends payment directly to me, I agree to immediately forward all payments that I have received for my care, and treatment, to WCAK. I understand and agree that I have been advised that I may be billed by WCAK and that this Assignment of Benefits and Agreement to Pay applies to any and all WCAK physician services, including both inpatient and outpatient charges, performed by my provider.

The undersigned understands that some items or services provided may not be covered by my insurance carrier, and I agree to be personally responsible for any such non-covered items or services in excess of the limits in my member benefit agreement. I understand that I am personally responsible for any item or service determined by my insurance company to be experimental, investigational, or to be non-covered for any other reason. I understand that I am personally responsible for any non-covered Medicare, Medicaid, Tricare items or services that are listed on the financial responsibility for non-covered items or services form. I am responsible for all copays, deductibles, and coinsurance established by my member benefit agreement.

The undersigned understands and agrees that all account balances are **due within 30 days of billing**. I also understand that if my account becomes delinquent, the account will be referred to an outside collection agency for payment resolution. If my account is referred to an outside collection agency, I agree to pay the reasonable attorney's fees, court costs and/or collection agency fees associated with the collection process.

\_\_\_\_\_  
(Printed Name of Patient, Parent, or Guardian)

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

\_\_\_\_\_  
Patient, Parent, Guardian Signature:



Allison van Haastert, MD  
Jessica Goldberger, MD  
Meagan Byrne, DO

Wynd Counts, MD \* Wendy Cruz, MD

Katie Ulmer, ANP  
Migel Hadley, ANP  
Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 \* (907)279-2273 Fax (907)258-7705 [www.wcakobgyn.com](http://www.wcakobgyn.com)

### INFORMED CONSENT – TELEMEDICINE APPOINTMENT

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through use of interactive video, audio, or other telecommunication technology. Additionally, a physical examination of you may take place, and video, audio and/or photo recordings may be taken.

#### ANTICIPATED BENEFITS:

- Improved access to medical care by enabling a patient to remain in their location while the healthcare provider provides care from a distant site.
- Limiting the spread of COVID-19.
- More efficient medical evaluation and management.

#### POSSIBLE RISKS:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- It may be determined that that information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation / treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all your medical records may result in adverse drug reactions or allergic reactions or other judgment errors.

#### BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

- I understand that I may expect anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
- I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed without my authorization.
- I understand that during the COVID-19 Pandemic, security measurements may be lessened in accordance with U.S. Department of Health and Human Services to ensure improved access to care.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time without affecting my right to future care or treatment.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative to my satisfaction.
- I understand that certain fees for service may be waived during the COVID-19 Pandemic depending on my insurance carrier. While all efforts will be made to follow guidelines during this fluid situation, I understand that I am still responsible for any co-payments or co-insurance that may apply, and if my medical insurance coverage is not sufficient to satisfy any excess cost(s), I will be responsible for payment.

I have read and understand the information provided above regarding telemedicine:

I **DO** consent to Telemedicine Appointments.

I **DO NOT** consent to Telemedicine Appointments.

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE



Allison van Haastert, MD  
 Jessica Goldberger, MD  
 Meagan Byrne, DO

Women's Care of Alaska

Wynd Counts, MD \* Wendy Cruz, MD

Katie Ulmer, ANP  
 Migel Hadley, ANP  
 Wendy Koehler, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 \* (907)279-2273 Fax (907)258-7705 [www.wcakobgyn.com](http://www.wcakobgyn.com)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

What brings you to our office today? \_\_\_\_\_

**ALLERGIES**  N/A – No known drug allergies

LIST DRUG, ENVIRONMENTAL AND FOOD ALLERGIES	REACTION

**CURRENT MEDICATIONS**  N/A – No medications

DRUG NAME	DOSE	DRUG NAME	DOSE

**GYN HISTORY / ANNUAL UPDATE**  N/A – I no longer have a menstrual cycle Age \_\_\_\_\_

Date last menstrual period began: \_\_\_\_\_ Menstrual cycles are:  Regular  Irregular

Age when periods started? \_\_\_\_\_ Menstrual bleeding is:  Light  Moderate  Heavy Periods last: \_\_\_\_\_ days

Cramps are:  N/A  Mild  Moderate  Severe Cramps last: \_\_\_\_\_ days

Spotting occurs between periods:  Yes  No Spotting occurs after intercourse:  Yes  No

**EXAM HISTORY**

Date of last dental exam: \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_  Normal  Abnormal

Date of last eye exam: \_\_\_\_\_ Date of last PAP: \_\_\_\_\_  Normal  Abnormal

Date of last colon screening: \_\_\_\_\_  Normal  Abnormal

**STD HISTORY**  N/A – I have never had a sexually transmitted disease

**Have you ever had any of the following STDs?** (✓ all that apply):

Chlamydia  Gonorrhea  Genital Warts  Herpes  Trichomonas  Syphilis  PID

Have you ever tested positive for HIV?  Yes  No

**SEXUAL HISTORY**  N/A – I have never been sexually active

Are you currently sexually active?  Yes  No -  Male  Female  Both

Did you begin sexual activity before the age of 16?  Yes  No If yes, what age did you start? \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

**CONTRACEPTION**  N/A – I am not currently using any form of birth control

<b>Current Birth Control Method:</b> <input type="checkbox"/> Condoms <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Depo Provera <input type="checkbox"/> Natural / Rhythm <input type="checkbox"/> IUD <input type="checkbox"/> Nexplanon® <input type="checkbox"/> Other _____
--

**PREGNANCY HISTORY**

Total number of times pregnant		Number of Cesarean Sections		Number of miscarriages	
Number of full-term deliveries		Number of living children		Number of elective abortions	

**PERSONAL / FAMILY MEDICAL HISTORY**  Box for Personal History or Family History of condition

Condition	Pers. Hx	Family Hx		Pers. Hx	Family Hx		Pers. Hx	Family Hx
Anemia			Fibroids			Liver Problems		
Anxiety			Fracture(s)			Lung Disease		
Arthritis			GI Reflux Disease			Migraine		
Asthma			GI (other) Disease			Osteopenia/Osteoporosis		
Autoimmune Disease			Heart Disease			Ovarian Cyst		
Cancer (type)			Hepatitis			PCOS		
Clotting Disorder			High Blood Pressure			Seizures		
Depression			High Cholesterol			Thyroid Disease		
Diabetes			Joint Pain			Tuberculosis		
Endometriosis			Kidney Infections/stones			OTHER		

**SURGICAL HISTORY**

---

---

---

---

---

**SOCIAL HISTORY / HABITS / PERSONAL SAFETY**

Do you follow a Special Diet? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type?: _____
Do you exercise? <input type="checkbox"/> Never <input type="checkbox"/> Rarely (1-2x/yr) <input type="checkbox"/> Occasionally (1-2x/month) <input type="checkbox"/> Often (1-2x/wk) <input type="checkbox"/> Regularly (3-5x/wk)
Tobacco/Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Packs/day: _____ Number of years: _____ Quit Date: _____
Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Drinks/day: _____ Drinks per week: _____ Quit Date: _____
Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Former Type? _____ Number of years: _____ Quit Date: _____
Has anyone close to you, ever threatened to, or physically hurt you? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone, including your partner, ever forced you to have sex? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you fear harm from anyone at home, or school, or anywhere else? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any concerns about your body image? <input type="checkbox"/> Yes <input type="checkbox"/> No

Allison van Haastert, MD  
 Jessica Goldberger, MD  
 Meagan Byrne, DO



Katie Ulmer, ANP  
 Migel Hadley, ANP  
 Wendy Koehler, ANP  
 Haley Gomez, ANP

2741 DeBarr Road, Suite C205 Anchorage, AK 99508 \* (907)279-2273 Fax (907)258-7705 [www.wcakobgyn.com](http://www.wcakobgyn.com)

**REVIEW OF SYSTEMS**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

What brings you to our office today? \_\_\_\_\_

Check only those conditions that you are CURRENTLY having now.

CONSTITUTIONAL	NOTES	GENITOURINARY	NOTES
Fever		Abnormal Bleeding	
Chills		Vaginal Discharge/odor	
Fatigue		Vaginal Itching/burning	
Weight Loss		Pelvic Pain	
Weight Gain		Menstrual Cramps	
<b>EYES</b>		Painful Intercourse	
Change in Vision		Genital Lump	
Double Vision		Fertility Concerns	
<b>HEENT</b>		Menopausal Concerns	
Earaches		<b>MUSCULOSKELETAL</b>	
Ringing in ears		Muscle Weakness	
Sinus Problems		Joint Stiffness	
Sore Throat		Joint Pain	
Mouth Sores		Joint Swelling	
Dry Mouth		<b>SKIN/BREAST</b>	
<b>CARDIOVASCULAR</b>		Breast Pain	
Chest Pain		Nipple Discharge	
Diff. breathing w/exertion		Breast Lumps	
Swelling of legs		Rash	
Palpitations		Ulcers	
Heart Murmurs		<b>PSYCHIATRIC</b>	
<b>RESPIRATORY</b>		Depression	
Wheezing		Mood Swings	
Spitting up blood		Anxiety	
Shortness of Breath		Suicidal Thoughts	
Cough		Homicidal Thoughts	
<b>GASTROINTESTINAL</b>		<b>ENDOCRINE</b>	
Diarrhea		Abnormal Thirst	
Constipation		Hot Flashes	
Nausea/vomiting		Tremors	
Bloody Stool		Cold/Heat Intolerance	
Abdominal Pain		<b>HEMATOLOGIC</b>	
Indigestion		Frequent Bruising	
Bloating		Cuts do not stop bleeding	
Liver Problem/Hepatitis		Enlarged Lymph nodes	
<b>GENITOURINARY</b>		<b>OTHER</b>	
Blood in Urine			
Pain with Urination			
Urgency			
Urinary Incontinence			
Urinary Frequency			



# Family History Questionnaire for Common Hereditary Cancer Syndromes

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Age of First Period:** \_\_\_\_\_ **Your Age When First Child Delivered (If applicable):** \_\_\_\_\_ **Age of Your Mother:** \_\_\_\_\_  
**Are you Menopausal:** \_\_\_\_\_ **Have you ever used hormone replacement therapy? Please circle Yes or No** If Yes, how long have you been it? \_\_\_\_\_  
**Has anyone in your family had genetic testing for hereditary cancer syndrome (Ex: BRCA or LYNCH)? Please circle Yes or No** If Yes, what was the result? \_\_\_\_\_  
**Best Contact Phone Number(s):** \_\_\_\_\_ **Email:** \_\_\_\_\_

Please mark below if there is a **personal or family history** of any of the following cancer and **indicate family relationship** and **their AGE at diagnosis** in the appropriate column. Consider parents, children, siblings, grandparents, aunts, uncles, and cousins.

Please Check			You (age at diagnosis)	Siblings/Children (Who + age at diagnosis) <i>Ex: Brother, 36 yrs</i>	Your Mother's side (Who + age at diagnosis) <i>Ex: Aunt, 44 yrs</i>	Your father's side (Who + age at diagnosis) <i>Ex: Grandpa, 65 yrs</i>
Y	N	Breast cancer				
Y	N	Breast cancer in both breasts or multiple primary breast cancers				
Y	N	Ovarian cancer				
Y	N	Male breast cancer				
Y	N	Are you of Ashkenazi Jewish descent				
Y	N	Uterine (endometrial) cancer ( <i>NOTE: do not include cervical cancer</i> )				
Y	N	Colon cancer				
Y	N	Stomach, kidney/urinary tract, brain, or small bowel/intestinal cancer ( <i>NOTE: Please circle or write appropriate cancer in column</i> )				
Y	N	10 or more colon polyps found in a lifetime				
Y	N	Prostate cancer				
Y	N	Pancreatic cancer (Col/BRCA)				
Y	N	Malignant melanoma				

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For Office Use Only**

**BRCA/Lynch/myRisk Testing Indicated?**      **Yes**    **No**  
**Patient offered hereditary cancer testing?**      **Yes**    **No**      If YES: **ACCEPTED**    **DECLINED:** \_\_\_\_\_  
**Follow-up appointment scheduled?**      **Yes**    **No**      Date of Appointment: \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**BRCA - Personal or Fam History**

- One person with (out to 2nd degree)
- Breast cancer at 45 or younger
  - Ovarian cancer at any age
  - Male breast cancer at any age
  - Breast cancer + Jewish Heritage
  - Bilateral Breast cancer at 50 or younger
  - Triple negative breast cancer at any age
  - Family history of known BRCA1 or BRCA2 mutations

**BRCA - Personal or Fam History**

- Two persons with (out to 3rd degree)
- 2 breast cancers w/ 1 ≤ 50 yrs
  - Breast & ovarian cancer (any age)
- Three persons with (out to 3rd degree)
- Breast and/or Ovarian and/or Pancreatic (any age) and/or aggressive prostate cancer

**Lynch Syndrome (Colon/Endometrial)**

- Personally affected with:
- Colon and/or Endometrial cancer at ≤ 50 yrs
  - Family history of known Lynch mutations
- Family History of Colon, Endometrial, or Lynch Cancers (out to 2nd degree) (ie. Gastric, ovarian, brain, kidney, small bowel)
- 1 or more Lynch cancers, 1 dx ≤ 50 yrs