

Oregon Cancer Genetics Survey

Please follow the skip instructions throughout the survey so you only answer the items and sections that are applicable to you. Your responses are **voluntary** and **confidential**. This survey does **not request protected health information**.

If you have questions: Please call Tara Horn at 503-725-8130, or email horn@pdx.edu. Return the completed survey in the enclosed postage-paid envelope to: Survey Research Lab, 1600 SW 4th Ave., Suite 900, Portland OR.

1. Do you currently see patients?

Yes

⋮

No

→ **If you answered NO, do not complete the remaining questions.**

Please return this survey in the envelope provided to ensure you do not receive future mailings.

2. When assessing a person’s risk for cancer in general, do you ask about family medical history?

Yes

No

Skip to #5

3. When you assess family history of cancer among patients without cancer, do you determine:

	Yes	No
Primary cancer site	<input type="checkbox"/>	<input type="checkbox"/>
First degree relatives (parents, siblings, children) who have had cancer	<input type="checkbox"/>	<input type="checkbox"/>
Maternal second degree relatives (grandparents, aunts, uncles, grandchildren, nieces, nephews, half-siblings) who have had cancer	<input type="checkbox"/>	<input type="checkbox"/>
Paternal second degree relatives (grandparents, aunts, uncles, grandchildren, nieces, nephews, half-siblings) who have had cancer	<input type="checkbox"/>	<input type="checkbox"/>
Age of diagnosis for relatives with cancer	<input type="checkbox"/>	<input type="checkbox"/>

4. How often do you use family medical history of cancer for patients without cancer to help decide:

	Always	Usually	Sometimes	Never
Cancer screening test(s) to recommend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The age to start screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The frequency of screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To refer the patient to a genetics specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other – related to cancer family history [please specify]: <div style="border: 1px solid black; height: 15px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. How many times in the past 12 months has a patient voluntarily shared with you their previously compiled family history (e.g., Surgeon General’s Family History, genealogy chart with medical information)?

_____ times [please estimate a single number, not a range]

Section A: Breast and Ovarian Cancer

6. In your practice, do you recommend breast and/or ovarian cancer **SCREENING** to patients without cancer?

Yes No Skip to #15 on Page 3

7. Have you performed, ordered, or recommended any of the following breast and/or ovarian cancer screening tests in the past 12 months for patients without cancer? **If YES**, estimate the number of times.

Screening Test	Performed, Ordered, or Recommended in Past 12 Months		[If YES] How many times in past 12 months?		
			Less than 5	5 to 50	More than 50
Mammography	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast MRI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CA-125	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trans-vaginal Ultrasound	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other [please specify]: <div style="border: 1px solid black; height: 15px; width: 100%; margin-top: 2px;"></div>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Have you ever ordered or recommended an **OncoVue test** (e.g., a multigene screening panel for patients without breast cancer) to determine a patient's breast cancer risk?

Yes Skip to #9 No

8a. If you have **never** ordered or recommended an OncoVue test, why not? [check all that apply]

- | | |
|--|---|
| <input type="checkbox"/> Clinical outcomes would not change
<input type="checkbox"/> Costs too much/insurance will not cover it
<input type="checkbox"/> I do not think the test is valid
<input type="checkbox"/> Other [please specify]: <div style="border: 1px solid black; width: 100%; height: 15px; margin-top: 2px;"></div> | <input type="checkbox"/> Practice guidelines do not include this test
<input type="checkbox"/> I am not familiar with the test
<input type="checkbox"/> This test is not relevant to any of my patients |
|--|---|

If you answered #8a, skip to #11 on Page 3

9. How often do you order or recommend OncoVue for the following reasons:

	Always	Usually	Sometimes	Never
The patient meets practice guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide future screening decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide prophylactic treatment decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient specifically requests it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less expensive than BRCA testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. How many times **in the past 12 months** have you ordered or recommended OncoVue?

_____ times [please estimate a single number, not a range]

11. Have you ever suspected a **BRCA mutation** in a patient **without** breast or ovarian cancer?

- Yes No [Skip to #15](#)

12. When you suspect a **BRCA mutation**, how often do you refer a patient **without** breast or ovarian cancer to a genetic specialist?

Always	Usually	Sometimes	Never
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[Skip to #12b](#)

12a. When you **DO NOT** refer a patient **without** breast or ovarian cancer to a genetic specialist, why not?
[check all that apply]

- I feel comfortable providing BRCA genetic counseling and testing myself
 There are no genetic specialists in my geographic area
 Costs too much/insurance will not cover it
 Other [please specify]:

12b. How many times **in the past 12 months** have you referred a patient **without** breast or ovarian cancer to a genetic specialist for consideration for **BRCA testing**?

_____ times [please estimate a single number, not a range - response can be "0"]

In item #12, if you answered that you ALWAYS refer to a genetic specialist, skip to #15

13. How often do you order or recommend **BRCA testing** for a patient **without** breast or ovarian cancer for the following reasons:

	Always	Usually	Sometimes	Never
The patient meets practice guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide future screening decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide prophylactic treatment decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient specifically requests it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How many times **in the past 12 months** have you ordered or recommended **BRCA testing** for a patient **without** breast or ovarian cancer?

_____ times [please estimate a single number, not a range]

The next set of questions relates to the treatment of breast and/or ovarian cancers.

15. Do you **TREAT** patients for breast and/or ovarian cancer?

- Yes No [Skip to #26 on Page 6](#)

16. Have you ever suspected a **BRCA mutation** in a patient **with** breast or ovarian cancer?

- Yes No [Skip to #20 on Page 4](#)

17. When you suspect a BRCA mutation, how often do you refer a patient **with** breast or ovarian cancer to a genetic specialist?

Always	Usually	Sometimes	Never
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[Skip to #17b](#)

17a. When you **DO NOT** refer a patient with breast or ovarian cancer to a genetic specialist, why not? [check all that apply]

- I feel comfortable providing BRCA genetic counseling and testing myself
- There are no genetic specialists in my geographic area
- Costs too much/insurance will not cover it
- Other [please specify]:

17b. How many times **in the past 12 months** have you referred a patient **with** breast or ovarian cancer to a genetic specialist for consideration for BRCA testing?

_____ times [please estimate a single number, not a range - response can be "0"]

In item #17, if you answered that you ALWAYS refer to a genetic specialist, skip to #20

18. How often do you order or recommend a BRCA test for a patient **with** breast or ovarian cancer for the following reasons:

	Always	Usually	Sometimes	Never
The patient meets practice guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide future screening decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide prophylactic treatment decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient specifically requests it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. How many times **in the past 12 months** have you ordered or recommended BRCA testing for a patient **with** breast or ovarian cancer?

_____ times [please estimate a single number, not a range]

20. For a patient **with breast cancer**, have you ever ordered or recommended a tumor gene expression profile test (e.g., OncoType DX, MammaPrint, H/I ratio)?

- Yes [Skip to #21 on Page 5](#) No

20a. If you have **never** ordered or recommended tumor gene expression profile tests for patients **with breast cancer**, why not? [check all that apply]

- Clinical outcomes would not change
- Costs too much/insurance will not cover it
- I do not think the test is valid
- Other [please specify]:
- Practice guidelines do not include this test
- I am not familiar with the test
- This test is not relevant to any of my patients

If you answered #20a, skip to #23 on Page 5

21. How often do you order or recommend a tumor gene expression profile test for a patient with breast cancer for the following reasons:

	Always	Usually	Sometimes	Never
The patient meets practice guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide future screening decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide chemotherapeutic treatment decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To help determine prognosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient specifically requests it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. How many times in the past 12 months have you ordered or recommended a tumor gene expression profile test for a patient with breast cancer?

_____ times [please estimate a single number, not a range]

23. For patients with breast cancer, have you ever ordered or recommended testing for CYP2D6 to predict the patient's response to tamoxifen?

Yes Skip to #24 No

23a. If you have never ordered or recommended CYP2D6 testing for these patients, why not?

[check all that apply]

- Clinical outcomes would not change
- Costs too much/insurance will not cover it
- I do not think the test is valid
- Practice guidelines do not include this test
- Other [please specify]:
- I am not familiar with the test
- I do not prescribe tamoxifen to my patients
- All relevant patients are prescribed tamoxifen regardless of their CYP2D6 status

If you answered #23a, skip to #26 on Page 6

24. How often do you order or recommend a CYP2D6 test for a patient with breast cancer for the following reasons:

	Always	Usually	Sometimes	Never
The patient meets practice guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide future screening decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide chemotherapeutic dosage decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To help determine prognosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient specifically requests it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. How many times in the past 12 months have you ordered or recommended CYP2D6 testing for a patient with breast cancer?

_____ times [please estimate a single number, not a range]

Section B: Colorectal Cancer

26. In your practice, do you recommend colorectal cancer **SCREENING** to patients without cancer?

- Yes No Skip to #35 on Page 7

27. Have you performed, ordered, or recommended any of the following colorectal cancer screening tests in the past 12 months for patients without cancer? **If YES**, estimate the number of times.

Screening Test	Performed, Ordered or Recommended in Past 12 Months		[If YES] How Many Times in Past 12 Months?		
			Less than 5	5 to 50	More than 50
Colonoscopy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In office Fecal Occult Blood Test (FOBT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At home Fecal Occult Blood Test (FOBT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sigmoidoscopy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Virtual Colonoscopy (CT Scan)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other [please specify]: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. Have you ever recommended a **fecal DNA test**?

- Yes Skip to #29 No

28a. If you have **never** ordered or recommended a fecal DNA test, why not? [check all that apply]

- | | |
|--|---|
| <input type="checkbox"/> Clinical outcomes would not change
<input type="checkbox"/> Costs too much/insurance will not cover it
<input type="checkbox"/> I do not think the test is valid
<input type="checkbox"/> Other [please specify]: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div> | <input type="checkbox"/> Practice guidelines do not include this test
<input type="checkbox"/> I am not familiar with the test
<input type="checkbox"/> This test is not relevant to any of my patients |
|--|---|

If you answered #28a, skip to #31 on Page 7

29. How often do you order or recommend a fecal DNA test for the following reasons:

	Always	Usually	Sometimes	Never
The patient meets practice guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide future screening decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide prophylactic treatment decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients are more likely to agree to this test compared to other tests for colorectal cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Test is less expensive than endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. How many times in the past 12 months have you ordered or recommended fecal DNA tests?

_____ times [please estimate a single number, not a range]

31. Have you ever suspected **Lynch syndrome** (also known as Hereditary Nonpolyposis Colorectal Cancer) in a patient **without** cancer?

- Yes No [Skip to #35](#)

32. If you suspect Lynch syndrome, how often do you refer a patient **without** cancer to a genetic specialist to consider testing?

Always	Usually	Sometimes	Never
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skip to #32b			

32a. When you **DO NOT** refer a patient with suspected Lynch syndrome to a genetic specialist, why not?
[check all that apply]

- I feel comfortable providing the genetic counseling and testing myself
 There are no genetic specialists in my geographic area
 Costs too much/insurance will not cover it
 Other [please specify]:

32b. How many times **in the past 12 months** have you referred a patient **without** cancer to a genetic specialist to consider testing for Lynch syndrome?

_____ times [please estimate a single number, not a range - response can be "0"]

In item #32, if you answered that you **ALWAYS** refer to a genetic specialist, skip to #35

33. How often do you order or recommend genetic testing for Lynch syndrome for patients **without** cancer for the following reasons:

	Always	Usually	Sometimes	Never
The patient meets practice guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide future screening decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide prophylactic treatment decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient specifically requests it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. How many times **in the past 12 months** have you recommended Lynch syndrome genetic testing for a patient **without** cancer?

_____ times [please estimate a single number, not a range]

The next set of questions relates to the treatment of colorectal cancer.

35. Do you **TREAT** patients for colorectal cancer?

- Yes No [Skip to #47 on Page 10](#)

36. Have you ever suspected **Lynch syndrome** (also known as Hereditary Nonpolyposis Colorectal Cancer) in a patient **with** cancer?

- Yes No [Skip to #40 on Page 8](#)

	Always	Usually	Sometimes	Never
37. If you suspect Lynch syndrome, how often do you refer a patient with cancer to a genetic specialist to consider testing for mutations in mismatch repair genes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Skip to #37b			

37a. When you **DO NOT** refer a patient with suspected Lynch syndrome to a genetic specialist, why not?

[check all that apply]

- I feel comfortable providing the genetic counseling and testing myself
- There are no genetic specialists in my geographic area
- It costs too much, or insurance does not cover it
- Other [please specify]:

37b. How many times **in the past 12 months** have you referred a patient **with** cancer due to suspected Lynch syndrome to a genetic specialist?

_____ times [please estimate a single number, not a range – response can be “0”]

In item #37, if you answered that you **ALWAYS** refer to a genetic specialist, skip to #40

38. How often do you order or recommend Lynch syndrome genetic testing (specifically mismatch repair genes) for patients **with** cancer for the following reasons:

	Always	Usually	Sometimes	Never
The patient meets practice guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide future screening decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide chemotherapeutic treatment decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To determine prognosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient specifically requests it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

39. How many times **in the past 12 months** have you ordered or recommended Lynch syndrome genetic testing (specifically mismatch repair genes) for a patient **with** cancer?

_____ times [please estimate a single number, not a range]

40. For patients with colorectal cancer, how often does your tumor pathology department **screen colorectal tumors** for:

	Always	Usually	Sometimes	Never	Don't Know
Microsatellite Instability (MSI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunohistochemistry (IHC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. Have you ever ordered or recommended **UGT1A1 testing** for a patient **with colorectal cancer** to predict the patient's response to irinotecan toxicity?

- Yes Skip to #42 on Page 9 No

41a. If you have **never ordered or recommended UGT1A1 testing, why not?** [check all that apply]

- Clinical outcomes would not change
- Costs too much/insurance will not cover it
- I do not think the test is valid
- Practice guidelines do not include this test
- Other [please specify]:
- I am not familiar with the test
- I do not prescribe irinotecan to my patients
- All relevant patients are prescribed irinotecan regardless of their UGT1A1 status

If you answered #41a, skip to #44

42. How often do you order or recommend a UGT1A1 test for a patient with colorectal cancer for the following reasons:

	Always	Usually	Sometimes	Never
The patient meets practice guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide chemotherapeutic treatment decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To help determine prognosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient specifically requests it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

43. How many times in the past 12 months have you ordered or recommended UGT1A1 testing for a patient with colorectal cancer?

_____ times [please estimate a single number, not a range]

44. Have you ever ordered or recommended KRAS testing for a patient with colorectal cancer to predict the effectiveness of anti-EGFR therapy (e.g., cetuximab, panitumumab)?

- Yes Skip to #45 No

44a. If you have **never ordered or recommended KRAS testing, why not?** [check all that apply]

- Clinical outcomes would not change
- Costs too much/insurance will not cover it
- I do not think the test is valid
- Practice guidelines do not include this test
- Other [please specify]:
- I am not familiar with the test
- I do not prescribe anti-EGFR therapy to my patients
- All relevant patients are prescribed anti-EGFR therapy regardless of their KRAS status

If you answered #44a, Skip to #47 on Page 10

45. How often do you order or recommend a KRAS test for a patient with colorectal cancer for the following reasons:

	Always	Usually	Sometimes	Never
The patient meets practice guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To guide chemotherapeutic treatment decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To help determine prognosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient specifically requests it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insurance companies require it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

46. How many times in the past 12 months have you ordered or recommended KRAS testing for a patient with colorectal cancer?

_____ times [please estimate a single number, not a range]

Section C: Cancer Medical Genetics Testing

47. How confident are you in your level of knowledge in medical genetics related to:	Not At All Confident	Somewhat Confident	Moderately Confident	Very Confident
a. Breast and ovarian cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Colorectal cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

48. Which of the following practice guidelines do you use to determine whether to order or recommend genetic testing for breast, ovarian, or colorectal cancer? [check all that apply]
- | | |
|--|---|
| <input type="checkbox"/> American Academy of Family Physicians (AAFP)
<input type="checkbox"/> American College of Gastroenterology (ACG)
<input type="checkbox"/> American College of Obstetricians and Gynecologists (ACOG)
<input type="checkbox"/> American College of Physicians (ACP)
<input type="checkbox"/> American Cancer Society (ACS)
<input type="checkbox"/> American Society of Clinical Oncology (ASCO)
<input type="checkbox"/> Other [please specify] : <input style="width: 600px; height: 20px;" type="text"/> | <input type="checkbox"/> Evaluation of Genomic Applications in Practice and Prevention (EGAPP)
<input type="checkbox"/> National Comprehensive Cancer Network (NCCN)
<input type="checkbox"/> U.S. Preventive Services Task Force (USPSTF)
<input type="checkbox"/> I do not use practice guidelines for screening or treating breast, ovarian, or colorectal cancer
<input type="checkbox"/> I do not order or recommend genetic tests for breast, ovarian, or colorectal cancer |
|--|---|

49. For each of the following genetic tests, please indicate whether or not a **sales representative has approached you, you have received marketing information in the mail, or you have heard presentations sponsored by genetic testing companies at meetings.**

Genetic Test	Approached by Sales Rep, Received Marketing in the Mail, and/or Heard Sponsored Presentations	
For Breast and Ovarian Cancer Screening and Testing:		
BRCA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
OncoVue or other multigene panel tests for breast cancer screening	<input type="checkbox"/> Yes	<input type="checkbox"/> No
OncoType DX or other gene expression tumor profile tests	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CYP2D6	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For Colorectal Cancer Screening and Testing:		
Fecal DNA	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MMR	<input type="checkbox"/> Yes	<input type="checkbox"/> No
UGT1A1	<input type="checkbox"/> Yes	<input type="checkbox"/> No
KRAS	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Section D: You and Your Practice

50. What medical credential do you have? [check only one]

- DO
 MD
 ND
 NP
 PA

51. How many years has it been since you completed all of your formal training, excluding continuing education?

_____ years

52. Which of the following categories best describes your main practice environment? [check only one]

- | | |
|---|---|
| <input type="checkbox"/> Solo practice
<input type="checkbox"/> Single-specialty physician-owned practice
<input type="checkbox"/> Multi-specialty physician-owned practice
<input type="checkbox"/> Group or staff model HMO
<input type="checkbox"/> Federally Qualified Health Center (FQHC) | <input type="checkbox"/> University hospital or clinic
<input type="checkbox"/> Hospital or health system-owned clinic, not associated with a university
<input type="checkbox"/> Other [please specify]:
<div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> |
|---|---|

53. Are you a member of the Oregon Rural Practice Research Network (ORPRN)? Yes No

54. Please indicate your practice specialty(ies). [check all that apply]

- | | |
|--|--|
| <input type="checkbox"/> Colorectal Surgery
<input type="checkbox"/> Family Medicine
<input type="checkbox"/> Gastroenterology
<input type="checkbox"/> General Surgery | <input type="checkbox"/> Internal Medicine
<input type="checkbox"/> Obstetrics and Gynecology
<input type="checkbox"/> Oncology
<input type="checkbox"/> Other(s) [please specify]:
<div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> |
|--|--|

55. On average, how many patients do you see each week?

- | | |
|--|--|
| <input type="checkbox"/> Fewer than 50 | <input type="checkbox"/> 101 to 150 |
| <input type="checkbox"/> 50 to 75 | <input type="checkbox"/> More than 150 |
| <input type="checkbox"/> 76 to 100 | |

56. Please list the zip code(s) for your practice sites.

57. What is your age? _____ years

58. What is your gender? Female Male

59. What is your race or ethnicity? [check all that apply]

- | | |
|---|--|
| <input type="checkbox"/> Black or African American
<input type="checkbox"/> White or Caucasian
<input type="checkbox"/> Hispanic or Latino/a
<input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Asian
<input type="checkbox"/> Other [please specify]:
<div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> |
|---|--|

Please use the space below to include any additional comments or details about the circumstances of your practice or the population you serve that will help us understand why you answered questions the way you did.

Thank You! Your response is appreciated.

Please take a moment now to return this survey in the postage-paid return envelope.