

Monash Health Referral Form

MEDICAL ONCOLOGY

Cancer or suspected cancer with no obvious primary site

REFERRAL

Mandatory content for first referral for patients with suspected cancer (eg based on CT scan) or proven metastatic cancer, where primary site is not known

Full name
Date of birth
Next of kin
Postal address (not PO Box)
Contact number
Mobile number
Email address
Medicare number
Referring GP details including **provider number**
Usual GP (if different)
Details of all medical specialists
Interpreter requirements
Confirm patient is aware of proven or likely cancer diagnosis

PLEASE NOTE DIAGNOSTIC TISSUE BIOPSY IS NOT REQUIRED PRIOR TO REFERRAL

include all correspondence and test results relating to cancer OR SUSPECTED CANCER including original imaging, histopathology reports, summaries of any previous cancers

Specific reason for referral: Workup for suspected cancer (not yet proven on biopsy)
 Proven cancer but site of origin not known
 Other (please specify): _____

T__N__M__ Stage: I / II / III / IV (if known) Date of diagnosis/suspected diagnosis: _____

Histology: attach actual report or tick if Monash Health

Molecular testing: attach actual report or tick if Monash Health

Site of disease : Liver / lung / bone / brain / peritoneal /other _____

Main current symptoms/problems:

Urgent: Hypercalcemia /SVC Obstruction / Spinal cord compression/uncontrolled symptom _____

Details of any past cancers :

Date:

Location:

Date/place of scheduled cancer follow up:

Clinician:

Comorbidities: Nil Present, list _____

Medication: attach date stamped list

Allergies: Nil Present, list _____

Relevant family history: Nil Present, list _____

Social history: Smoker Y/N Dust/asbestos exposure Y/N

Other relevant details:

Monash Health Referral Form

MEDICAL ONCOLOGY

COLORECTAL CANCER

REFERRAL

Mandatory content
for first referral to
Colorectal Cancer
at Monash Health

Full name
Date of birth
Next of kin
Postal address (not PO Box)
Contact number
Mobile number
Email address
Medicare number
Referring GP details including **provider number**
Usual GP (if different)
Details of all medical specialists
Interpreter requirements
Confirm patient is aware of proven or likely cancer diagnosis

Include all correspondence and test results relating to cancer including original histopathology reports, summaries of all treatment (including radiotherapy) and letters from all cancer specialists

Specific reason for referral: Workup for suspected colorectal cancer
 (neo) adjuvant treatment
 Definitive treatment with chemoradiation
 Treatment of metastatic disease
Other (please specify): _____

TNM stage:

Histology: attach actual report or tick if at Monash Health

Molecular testing: attach actual report or tick if at Monash Health

Ensure MSI testing done for all stages and RAS/RAF testing done for Stage IV patients. Indicate if pending.

Date of diagnosis:

Imaging/test results: attach actual reports or tick if at Monash Health

Site of metastases:

Main current symptoms/problems:

Details of cancer surgery:

Surgeon:

Details of radiation (or enclose treatment summary):

Site:

Details of other cancer treatment received or planned:

Date:

Location:

Date:

Location:

Date:

Date/place of scheduled cancer follow up:

Comorbidities:

Clinician:

Medication: attach date stamped list

Allergies:

Relevant family history:

Other relevant details:

Monash Health Referral Form

MEDICAL ONCOLOGY

GYNAECOLOGICAL CANCER

REFERRAL

Mandatory content
for first referral to
**Gynaecological
Cancers** at
Monash Health

Full name
Date of birth
Next of kin
Postal address (not PO Box)
Contact number
Mobile number
Email address
Medicare number
Referring GP details including **provider number**
Usual GP (if different)
Details of all medical specialists
Interpreter requirements
Confirm patient is aware of proven or likely cancer diagnosis

*Include all correspondence and test results relating to cancer including **original histopathology reports, summaries of all treatment (including radiotherapy) and letters from all cancer specialists***

Specific reason for referral: Workup for suspected cancer
 (neo) adjuvant treatment
 Definitive treatment with chemoradiation
 Treatment for metastatic/recurrent disease
 Other (please specify): _____

Stage: I / II / III / IV Date of diagnosis: _____
Histology: attach actual report or tick if Monash Health
Genetic testing (eg BRCA/Lynch syndrome): attach actual report or tick if Monash Health
Imaging/test results: attach all actual reports or tick if at Monash Health
Site of metastases: Peritoneal / nodal / liver / lung / bone / brain / peritoneal
Main current symptoms/problems:

Details of cancer surgery: Date: Location:
Radiation (or enclose treatment summary): Nil or Date: Location:
Site: _____ Intent: curative palliative
Details of other cancer treatment received or planned:

Date/place of scheduled cancer follow up: Clinician:
Comorbidities: Nil Present, list _____

Medication: attach date stamped list
Allergies: Nil Present, list _____
Relevant family history: Nil Present, list _____
Social history:
Other relevant details:

Monash Health Referral Form

MEDICAL ONCOLOGY

Head & Neck CANCER

REFERRAL

Mandatory content
for first referral to
Colorectal Cancer
at Monash Health

Full name
Date of birth
Next of kin
Postal address (not PO Box)
Contact number
Mobile number
Email address
Medicare number
Referring GP details including **provider number**
Usual GP (if different)
Details of all medical specialists
Interpreter requirements
Confirm patient is aware of proven or likely cancer diagnosis

*Include all correspondence and test results relating to cancer including **original histopathology reports, summaries of all treatment (including radiotherapy) and letters from all cancer specialists***

Specific reason for referral: Workup for suspected cancer
 Definitive treatment with chemoradiation
 Treatment for metastatic disease
 Other (please specify): _____

Primary Site of Cancer _____
T__N__M__ Stage: I / II / III / IV Date of diagnosis: _____

Histology: attach actual report or tick if Monash Health
Molecular testing (if applicable): attach actual report or tick if Monash Health
Imaging/test results: attach all actual reports or tick if at Monash Health
Site of metastases: Liver / lung / bone / brain / peritoneal
Main current symptoms/problems: _____

Details of cancer surgery: Date: Location:
Radiation (or enclose treatment summary): Nil or Date: Location:
Site: _____
Intent: curative palliative
Details of other cancer treatment received or planned: _____

Date/place of scheduled cancer follow up: Clinician:
Comorbidities: Nil Present, list _____

Smoking History

Medication: attach date stamped list
Allergies: Nil Present, list _____
Relevant family history: Nil Present, list _____
Social history:
Other relevant details:

Monash Health Referral Form

MEDICAL ONCOLOGY

UPPER GASTROINTESTINAL CANCER

REFERRAL

Mandatory content for first referral to Upper Gastrointestinal cancer service at Monash Health

- Full name
- Date of birth
- Next of kin
- Postal address (not PO Box)
- Contact number
- Mobile number
- Email address
- Medicare number
- Referring GP details including **provider number**
- Usual GP (if different)
- Details of all medical specialists
- Interpreter requirements
- Confirm patient is aware of proven or likely cancer diagnosis**

Include all correspondence and test results relating to cancer including original histopathology reports, summaries of all treatment (including radiotherapy) and letters from all cancer specialists

- Specific reason for referral: Workup for suspected cancer
 (neo) adjuvant treatment
 Definitive treatment with chemoradiation
 Treatment for metastatic disease
 Other (please specify): _____

T ___ N ___ M ___ Stage: I / II / III / IV Date of diagnosis: _____

Histology: attach actual report or tick if Monash Health

Molecular testing: attach actual report or tick if Monash Health

Ensure MSI and Her2 testing done for all stages of gastric cancer. These need to be ordered from the lab housing diagnostic tissue. Indicate if Monash Health or other Indicate if pending

Imaging/test results: attach all actual reports or tick if at Monash Health

Site of metastases: Liver / lung / bone / brain / peritoneal

Main current symptoms/problems:

Details of cancer surgery:

Radiation (or enclose treatment summary): Nil or Date: _____ Location: _____

Site: _____ Intent: curative palliative

Details of other cancer treatment received or planned:

Date/place of scheduled cancer follow up: _____ Clinician: _____

Comorbidities: Nil Present, list _____

Medication: attach date stamped list

Allergies: Nil Present, list _____

Relevant family history: Nil Present, list _____

Social history:

Patient weight (state date) _____ kg on _____

Other relevant details:

Monash Health Referral Form

MEDICAL ONCOLOGY

NEUROENDOCRINE TUMOURS

REFERRAL

Mandatory content
for first referral to
**Neuroendocrine
Tumours Clinic** at
Monash Health

Full name
Date of birth
Next of kin
Postal address (not PO Box)
Contact number
Mobile number
Email address
Medicare number
Referring GP details including **provider number**
Usual GP (if different)
Details of all medical specialists
Interpreter requirements
Confirm patient is aware of proven or likely cancer diagnosis

*Include all correspondence and test results relating to cancer including **original histopathology reports, imaging studies, summaries of all treatment (including radiotherapy/PRRT) and letters from all cancer specialists***

Specific reason for referral: Workup for suspected cancer OR new diagnosis
 Transfer of care- already under treatment
 Treatment for metastatic disease
 Other (please specify): _____

Date of diagnosis: _____

Histology: attach actual report or tick if Monash Health
Ki67 and mitotic rate : attach actual report or tick if Monash Health

Imaging/test results including GATATE/FDG PET: attach all actual reports or tick if at Monash Health

Site of primary :

Main current symptoms/problems:

Details of cancer surgery (if relevant):

Date:

Location:

Radiation or Peptide Receptor Radionuclide Therapy (PRRT) (or enclose treatment summary):

Nil or Date:

Location:

Site: _____

Intent: curative palliative

Details of other cancer treatment received or planned:

Date/place of scheduled cancer follow up:

Clinician:

Comorbidities: Nil Present, list _____

Medication: attach date stamped list

Allergies: Nil Present, list _____

Relevant family history: Nil Present, list _____

Social history:

Other relevant details:

Monash Health Referral Form

MEDICAL ONCOLOGY

UROLOGICAL CANCER

REFERRAL

Mandatory content
for first referral to
Urological Cancer
at Monash Health

Full name
Date of birth
Next of kin
Postal address (not PO Box)
Contact number
Mobile number
Email address
Medicare number
Referring GP details including **provider number**
Usual GP (if different)
Details of all medical specialists
Interpreter requirements
Confirm patient is aware of proven or likely cancer diagnosis

*Include all correspondence and test results relating to cancer including **original histopathology reports, summaries of all treatment (including radiotherapy) and letters from all cancer specialists***

Specific reason for referral: Workup for suspected cancer
 (neo) adjuvant treatment
 Definitive treatment with chemoradiation
 Treatment for metastatic disease
 Other (please specify): _____

T__N__M__ Stage: I / II / III / IV Date of diagnosis: _____

Histology: Attach actual report or tick if Monash Health

Molecular testing: Attach actual report or tick if Monash Health

Imaging/test results: Attach all actual reports or tick if at Monash Health

Main current symptoms/problems:

Cancer surgery procedure:

Date:

Location:

Radiation (or enclose treatment summary): Nil or

Date:

Provider:

Site: _____

Intent: Curative or Palliative

Details of other cancer treatment received or planned:

Date/place of scheduled cancer follow up:

Clinician:

Comorbidities: Nil Present, list _____

Medication: attach date stamped list

Allergies: Nil

Present, list _____

Relevant family history: Nil

Present, list _____

Social history:

Other relevant details:

Monash Health Referral Form

MEDICAL ONCOLOGY

CLINICAL TRIALS

REFERRAL

Mandatory content for first referral to Oncology Trials at MHTP Clinical Trials Centre (CTC) located at MMC, Clayton

FOR A FULL LIST OF ONCOLOGY CLINICAL TRIALS AT MONASH HEALTH click [here](#)

Full name
Date of birth
Next of kin
Postal address (not PO Box)
Contact number
Mobile number
Email address
Medicare number
Referring GP details including **provider number**
Usual GP (if different)
Details of all medical specialists
Interpreter requirements
Confirm patient is aware of referral for clinical trial

Please attach: **original histopathology, latest imaging, treatment summaries, medication list, all relevant correspondence, details of all clinicians**

Name of trial (if known): _____ PICF given

ECOG: 0 / 1 / 2 (3 and 4 not accepted)

Type of cancer: _____ Histology: _____

Date of diagnosis: _____ attach report or tick if Monash Health

Molecular results: _____ attach report or Monash Health

Stage of cancer: at diagnosis: I / II / III / IV at referral: I / II / III / IV

Brain metastases: No Yes Treated: No Yes _____

Steroids: No Yes, type / dose / schedule: _____

Anticoagulation: No Yes, type / dose / schedule: _____

Measurable disease by RECIST criteria: Yes No U/K

Disease Evaluable Yes No U/K

Lesion amenable to biopsy: No Yes, site _____

Prior cancer surgery: No Yes _____

Prior radiotherapy: No Yes _____

Number of prior systemic therapies (chemo / immuno / targeted / hormones): _____

Details (regimen, number of cycles, best response): _____

Estimated prognosis:

Comorbidities:

Medications (attach date stamped list) or list each drug, dose, duration, indication: