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
nclude 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: **Date:**
Surgeon: **Location:**
Details of radiation (or enclose treatment summary): **Date:** **Date:**
Site: **Location:**
Details of other cancer treatment received or planned:

Date/place of scheduled cancer follow up: **Clinician:**
Comorbidities:

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: **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:
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: