REFRESH

Illawarra Shoalhaven Breast MDT Referral Form

SUBMIT

PATIENT DETAILS

SURNAME: _____ FIRST NAME: _____ M ◯ F ◯

ISLHD MRN: _____ DOB: _____ GP: _____

REFERRER

SURGEON ◯ SPECIALIST ◯ MEDICAL ONCOLOGIST ◯ RADIATION ONCOLOGIST ◯

NAME: _____

1ST DATE REFERRED TO SPECIALIST _____ 1ST CONSULTATION DATE _____

TRIAGE CATEGORY

1. For priority discussion	2. For Discussion	3. Not for Discussion
1Ai Neo-adjuvant candidate ◯	2Ai Higher risk invasive ◯	3A Low grade DCIS ◯
1Aii Invasive – possible genetic ◯	2Aii Complex metastatic ◯	
1Aiii Complex medical History ◯	2Bi Low-mod risk invasive ◯	
	2Bii Intermed/high grade DCIS/LCIS ◯	
	2Ci New issue - Pt previously treated ◯	
	2Cii New issue - Pt currently treated ◯	

WORK-UP

PRESENTATION: BreastScreen ◯ Symptomatic ◯ Screening Other ◯ Self-detected ◯

PS (ECOG): Select an item

IMAGING

	RADIOLOGY PROVIDER	DATE	TYPE
1.	Select an item	_____	Select an item
2.	Select an item	_____	Select an item
3.	_____	_____	_____

SURGERY / PATHOLOGY

	PROCEDURE	DATE	PATHOLOGY PROVIDER	EPISODE NO.
1.	Select an item	_____	Select an item	_____
2.	Select an item	_____	Select an item	_____
3.	_____	_____	_____	_____

CLINICAL QUESTION

_____