REFRESH SUBMIT

Illawarra Shoalhaven Neuro MDT Referral Form

PATIENT DETAILS

SURNAME: _____ FIRST NAME: _____ SEX 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 New Neuro cancer diagnosed ◯ 2Ai Benign neuro tumour ◯

1Aii New metastases diagnosed ◯ 2Aii Patient w/out diagnosis ◯

1Bi Re-discuss New cancer ◯ 2Bi Re-discuss benign tumour ◯ 3B Data only ◯

1Bii Re-discussion of metastases ◯

WORK-UP

PRESENTATION: Asymptomatic ☐ Symptomatic ☐ Screen detected ☐

EXTENT OF SURGERY: Bx Only ◯ Resection: Subtotal ◯ Near Total ◯ Gross Total ◯

Other ◯ Unknown ◯ Nil Surgery ◯

PS (ECOG): Select an item

FITNESS FOR TREATMENT: Yes ☐ No ☐ Unsure ☐

CANCER SITE: Brain ☐ Spinal Cord ☐ Nerve ☐ Overlapping ☐ Unknown ☐

Other ☐

IMAGING

	RADIOLOGY PROVIDER	DATE	TYPE
1.	Select radiology company		Select type
2.	Select radiology company		Select type
3.			

SURGERY/PATHOLOGY

	PROCEDURE	DATE	PATHOLOGY PROVIDER	EPISODE NO.
1.	Select an item		Select pathology company	
2.			Select pathology company	

CLINICAL QUESTION

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