



Illawarra Shoalhaven UGI 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 cancer – curative intent | <input type="checkbox"/> | 2Ai Imaging Abnormality | <input type="checkbox"/> |
| 1Aii New cancer – QoL intent | <input type="checkbox"/> | 2Aii Post-surgery Review | <input type="checkbox"/> |
| 1Bi New cancer – Palliative Intent | <input type="checkbox"/> | 2Bi Re-discussion | <input type="checkbox"/> |
| 1Bii Complex metastatic cancer | <input type="checkbox"/> | 2Bii Pre-malignant lesions | <input type="checkbox"/> |
| | | 3B Data only | <input type="checkbox"/> |

WORK-UP

PRESENTATION: Screening Symptomatic Surveillance

SYMPTOMS: Swallowing problems Nausea/Vomiting Bleeding

Anorexia/weight loss Pain Jaundice Other

PS (ECOG): _____

FITNESS FOR TREATMENT: Yes No Unsure

CANCER SITE: Oesophageal & OG Junction Stomach Hepatobiliary

Pancreas Small Bowel Other Unknown

IMAGING

RADIOLOGY PROVIDER	DATE	IMAGE TYPE 1	IMAGE TYPE 2
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1. _____

2. _____

3. _____

SURGERY/PATHOLOGY

PROCEDURE	DATE	PATHOLOGY PROVIDER	EPISODE NO.
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1. _____

2. _____

CLINICAL QUESTION

At risk of Developing Diabetes Post Whipples: Yes No Unsure