**Referral for non-urgent genetic assessment to**

**RMH Familial Cancer Centre**

**Professor Geoff Lindeman/Associate Professor Paul James /Associate Professor Alison Trainer**

Referring Clinician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department & Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient details or UR sticker:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please use template for urgent referrals**

**Please refer patients meeting the NBOCC high risk category or guidelines for referral on eviQ.org.au**

**Details of personal/family history or cancer** *(essential for triage)*

*(site of primary cancers, age of diagnoses, relationship to patient, pathology information if known)*

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**Genetic assessment required to inform treatment?**

 **Histopathology report attached**

 *(essential for personal history cancer if not available on RMH CIS)*

 **I have discussed this referral with the patient**

 *(essential)*

Discussed at RMH breast MDT

Short term prognosis uncertain *(FCC to consider DNA storage)*

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_

**Send forms to: Fax:** 03 9342 4267 **Email:** familycancer@mh.org.au

 **Tel:** 03 9342 7151 **Web:** [www.thermh.org.au](http://www.thermh.org.au)

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