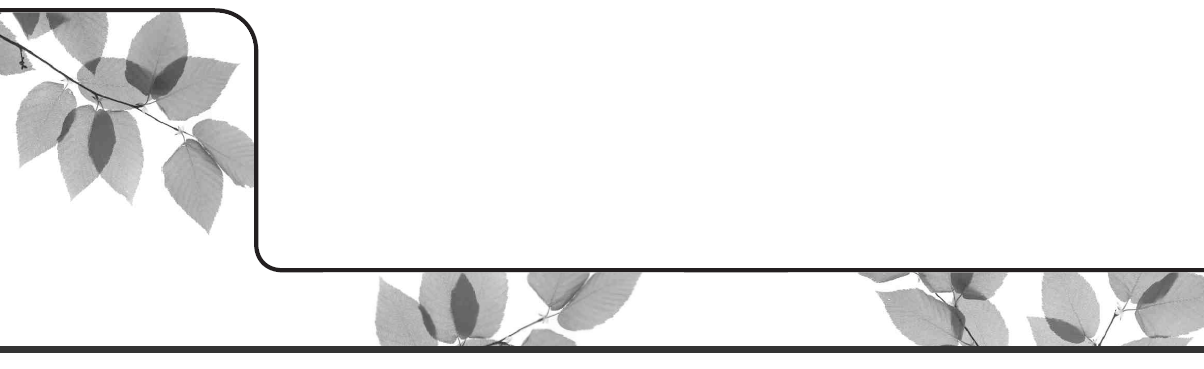
**Referral for URGENT genetic assessment to**



**RMH Familial Cancer Centre**

*(not for standard referrals)*

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for urgent genetics assessment:**

*\*Please be aware that urgent assessment delays access for other patients*

Genetics assessment required to inform treatment *(complete treatment info)*

Short term prognosis uncertain

*(Consider DNA storage)*

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Histopathology report attached**

*(essential)*

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

*(essential)*

**Family history details** *(essential)*

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

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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

**Treatment information required for rapid triage:**

Chemotherapy recommended: Yes / No

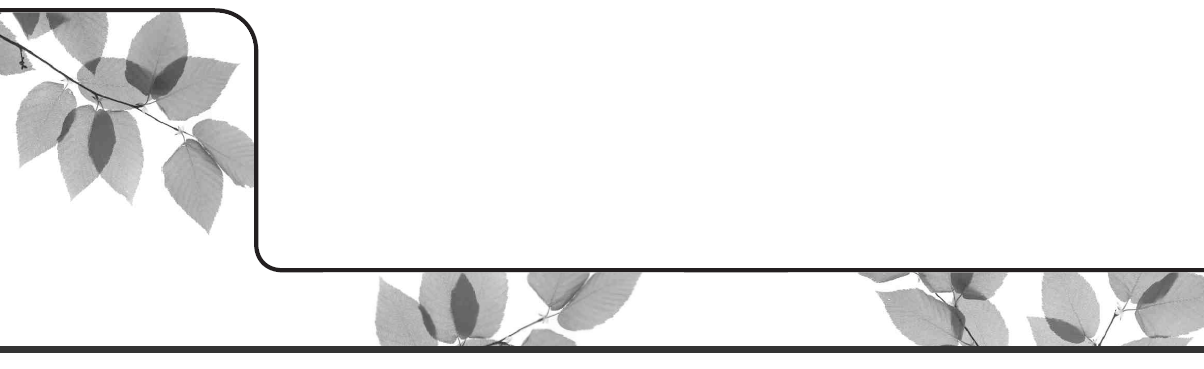
Planned finish date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How will genetics assessment impact treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

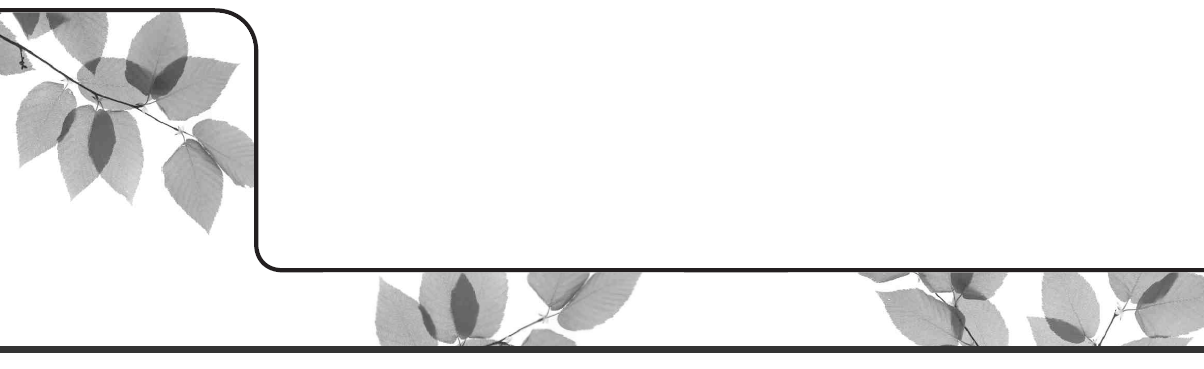
If assessed by FCC as eligible for genetic testing, result required by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



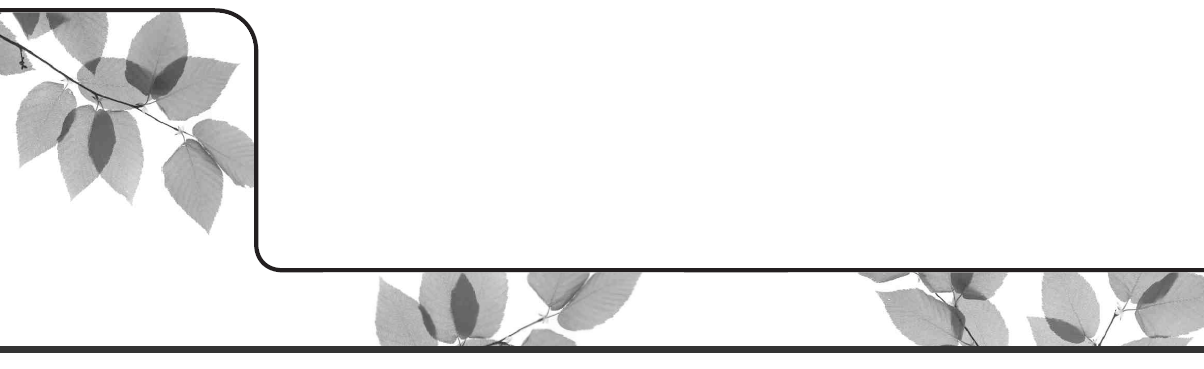
**Send forms to: Fax:** 03 9342 4267 **Email:** [familycancer@mh.org.au](mailto:familycancer@mh.org.au)

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



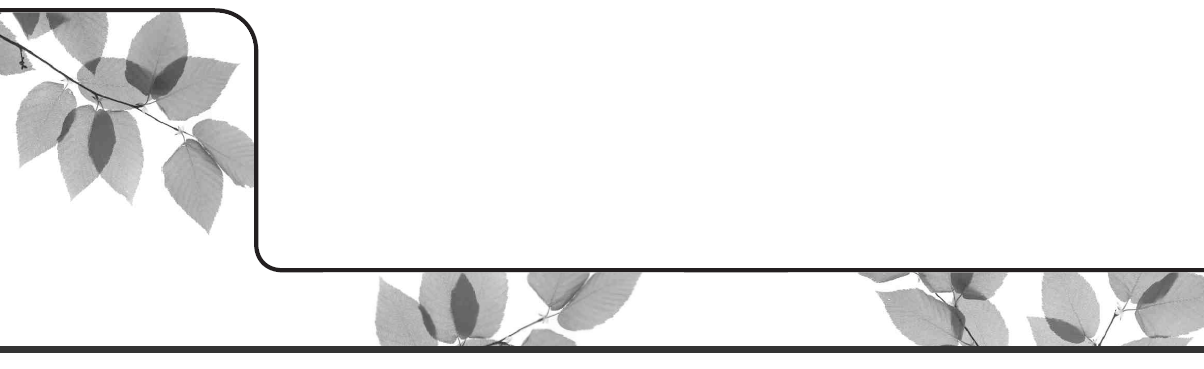
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