REFRESH SUBMIT

Illawarra Shoalhaven Lung MDT Referral Form

PATIENT DETAILS

SURNAME: _____ FIRST NAME: _____ SEX M ◯ F ◯

ISLHD MRN: DOB: GP: _____

REFERRER

SURGEON ◯ SPECIALIST ◯ MEDICAL ONCOLOGIST ◯ RADIATION ONCOLOGIST ◯

SPECIALIST DOCTOR 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 ◯	2Ai New issue - Imaging Abnormal ◯	
1Aii New cancer – QoL intent ◯	2Aii Post-surgical review ◯	3A Treatment declined ◯
1Aiii New cancer – Palliative Intent ◯	2Aiii New Metastases to lung ◯	3B Data only ◯
1Bi Complex metastatic cancer ◯	2Bi Imaging *suggests* cancer ◯	
1Bii New cancer – rediscuss ◯	2Bii Clinical review *suggests* cancer ◯	

WORK-UP

PRESENTATION: Incidental Imaging ☐ Symptomatic ☐ Asymptomatic ☐ Surveillance ☐

SYMPTOMS: Chest Pain ☐ Cough ☐ Dysphagia ☐ Dyspnoea/SOB ☐ Weight Loss ☐ Lethargy ☐

CO-MORBIDITIES: Smoker - Never ◯ Ex ◯ Current ◯ Pack Years _____

Respiratory condition ☐ EToH (high) ☐ Cardiac ☐ Prior Cancer _____

PS (ECOG): Select an item

FITNESS FOR RADICAL TREATMENT: Yes ☐ No ☐ Unsure ☐

CANCER SITE: Main Bronchus ◯ Upper lobe ◯ Middle lobe ◯ Lower lobe ◯

Overlapping ◯ Lung NOS ◯ Mediastinal LN ☐ LNs ☐ Other ◯ _____ Unknown ◯

IMAGING

	RADIOLOGY PROVIDER	DATE	TYPE
1.	Select Radiology Provider		Select item
2.	Select Radiology Provider		Select item
3.			

SURGERY/PATHOLOGY

	PROCEDURE	DATE	PATHOLOGY PROVIDER	EPISODE NO.
1.	Select Item		SEALS - NSW Health Pathology	
2.	Select Item		Select Pathology Company	
3.				

CLINICAL QUESTION

_____

Please tick if surgical input is requested: ☐