REFRESH

Illawarra Shoalhaven UGI MDT Referral Form

SUBMIT

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	◯	2Ai Imaging Abnormality	◯		
1Aii New cancer – QoL intent	◯	2Aii Post-surgery Review	◯		
1Bi New cancer – Palliative Intent	◯	2Bi Re-discussion	◯	3B Data only	◯
1Bii Complex metastatic cancer	◯	2Bii Pre-malignant lesions	◯		

WORK-UP

PRESENTATION: Screening ◯ Symptomatic ◯ Surveillance ◯

SYMPTOMS: Swallowing problems ☐ Nausea/Vomiting ☐ Bleeding ☐

Anorexia/weight loss ☐ Pain ☐ Jaundice ☐ Other _____

PS (ECOG): Select ECOG

FITNESS FOR TREATMENT: Yes ◯ No ◯ Unsure ◯

CANCER SITE: Oesophageal & OG Junction ◯ Stomach ◯ Hepatobiliary ◯

Pancreas ◯ Small Bowel ◯ Other ◯ Unknown ◯

IMAGING

	RADIOLOGY PROVIDER	DATE	TYPE	
1.	Select an item	_____	Select an item	Select an item
2.	Select an item	_____	Select an item	Select an item
3.	Select an item	_____	Select an item	Select an item

SURGERY / PATHOLOGY

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

CLINICAL QUESTION

_____