

Gynae-Oncology Referral Form

****FORMS MUST BE TYPED****

Referring to **Mater Misericordiae** **St. Vincent's**

Patient aware of possible diagnosis **Yes** **No**

Patient Details:

Date of referral:						
Title	First name	Surname	D.O.B	Age	Contact # 1	Contact # 2
Address		First language:		Interpreter	Yes	No
		Additional needs Hearing impaired Intellectual disability		Visually Impaired Wheelchair user		
Carer / next of kin name & contact						

Referring Team Details:

Referring consultant name, hospital & speciality	Contact name
	Contact number

Clinical Details:

Parity	Presenting symptoms
BMI MANDATORY	
ECOG Performance Status:	0 – Fully active and able to carry out all pre-disease performance without restriction 1 – Restricted in strenuous activity and able to carry out sedentary work 2 – Ambulatory and capable of all self-care up to 50% time 3 – Capable of limited self-care and confined to bed or chair 50% time 4 – Completely disabled
Hormonal status Post-menopausal Pre-menopausal On HRT On OCP	Medical history Asthma COPD HIV CKD Allergies Diabetes Ischemic heart disease Hypertension Known BRCA carrier Known lynch syndrome carrier Previous cancer Diagnosis Family history of cancer
Comment:	Other comorbidities & relevant medical history:
Surgical history	

Please email form to:

Mater Misericordiae: gynaeonc.mdt@mater.ie

Discs to be posted to Gynae MDT Coordinator, C/o The post room, Mater Public Hospital, Eccles Street, Dublin 7

Or St. Vincent's: gynae_onc_mdt@svhg.ie

Discs to be posted to Gynae MDT Coordinator, St Vincent's Hospital, Elm Park, Dublin 4

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Smoker Yes No Ex Smoker Pack Years	Anti Coagulation No Yes Specify if Yes	Medications
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Select site of referral: Tests in bold are mandatory. Tick if complete.

Cervix	Ovarian / Primary Peritoneal/ Fallopian	Endometrial	Vulval	Choriocarcinoma
MRI Pelvis <input type="checkbox"/>	MRI Pelvis <input type="checkbox"/>	MRI Pelvis <input type="checkbox"/>	CT TAP <input type="checkbox"/>	CT TAP <input type="checkbox"/>
Pet Scan <input type="checkbox"/>	CT TAP <input type="checkbox"/>	Histology <input type="checkbox"/>	MRI <input type="checkbox"/>	C X-Ray <input type="checkbox"/>
Histology <input type="checkbox"/>	Histology <input type="checkbox"/>	CT TAP <input type="checkbox"/>	Histology <input type="checkbox"/>	Histology <input type="checkbox"/>
U + E <input type="checkbox"/>	Tumour Markers <input type="checkbox"/>	Mandatory for grade 3 or serous		
FBC <input type="checkbox"/>				

Results Summary: ****Reports must be sent with referral**

HISTOLOGY	Report Attached Yes

RADIOLOGY	Report Attached Yes	On NIMIS
		If not on NIMIS discs must be sent by post to address below

TUMOUR MARKERS	
CA125	BHCG
CEA	AFP
CA 19.9	LDH
**Reports must be attached for U&E (cervix cancer only) and FBC	

COMMENTS:

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