***Sign completed referral forms and e-mail to*** [***CCTCPatientReferrals@austin.org.au***](mailto:CCTCPatientReferrals@austin.org.au)

**AUSTIN CCTC – Patient Referral Form**

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| **Referring Doctor***:* | | | | | | | |
| Name: [Name] | | |  | Practice Name: [Practice Name] | | |  |
| Provider Number: [Provider Number] | |  | | Practice Address: [Practice Address] | | |  |
| Phone Number: [Practice Phone] | | |  | Fax or Email: [Practice Fax/Email] | | |  |
| **MANDATORY SIGNATURE:** |  | | | |  |  | |

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| **Has the patient been discussed with a Doctor at Austin Health?   No   Yes - Doctor Name:** [Doctor Name] |

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| **Reason for referral***:* Consideration for clinical trial  **Date of referral:** [Enter date dd/mm/yy] |

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| **Please select the services you wish to refer the patient to:** | |
| Breast | Lung |
| GU | Lymphoma/CLL |
| Head & Neck/Brain | Leukemia/MDS |
| Melanoma/Skin | Multiple Myeloma |
| Phase I Solid Tumour | Bone Marrow Transplant |
| GI | Other - [Specify] |

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| **PATIENT DETAILS** | | | | | |
| Last Name: [Last name] |  | First Name: [First name] |  | | |
| Date of Birth: [DOB] |  | Sex: [Sex] |  | | |
| Phone Number: [Phone] |  | Email address: [Email] | |  | |
| Address: [Address] | | | | | |
| Medicare Number: [Medicare] | | | | | |
| Interpreter required: No  Yes – please specify: [Language] | | | | |  |
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| **Required investigations/attachments***:*  *The tests identified below are to be completed and results forwarded with the referral:* | | |
| FBE | Chemistry incl. LFTs | |
| Histology | Diagnostic Imaging Report(s) | |
| **If interstate, please ensure patient brings CD with most recent imaging.** | | |
| Relevant Tumour markers/ Other (Specify) [Specify] | | |
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| **Relevant Clinical Information:** | |
| **Current Diagnosis:** [Current Diagnosis]  **Specify Most Recent Treatment:** *(inclusive of Chemotherapy, Radiotherapy, Immunotherapy and Surgery)*  [Specify]  **Date of last treatment:** [Date] OR  Ongoing  **Specify any other past lines of treatment:** *(inclusive of Chemotherapy, Radiotherapy, Immunotherapy and Surgery)*  [Specify]  **Other Relevant Clinical Information: [**Other Relevant Clinical Information]  **Current Status:**  ECOG:  0 1 2  Measurable disease on most recent imaging  YES  NO  Current Symptoms:  [Current Symptoms] | |

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| **Current Medications***:* |
| [Current Medications] |

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| **Past Medical History/ Co-morbidities***:* |
| [Past Medical History] |

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| **CCTC Use Only** | | | | | |
| Date Actioned: |  | Triaged by: |  | UR: |  |