GYNAECOLOGICAL CANCER CENTRE

Health
South Eastern Sydney
Local Health District

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THE ROYAL HOSPITAL FOR WOMEN
GYNAECOLOGICAL ONCOLOGY REFERRAL

REFERRER DETAILS			
NAME:		**CONSULTANT & PROVIDER NO:**	
LOCATION / HOSPITAL:			

PATIENT DETAILS			
NAME:		**MRN:**	
DOB (AGE):		**MEDICARE NUMBER:**	
ADDRESS:		**CONTACT NUMBER:**	
GP:			
Patient is aware of referral: YES / NO			
Interpreter required Yes/ No		**Language:**	

REASON FOR REFERRAL:	
PRESENTING COMPLAINT:	
PAST HISTORY:	
FAMILY HISTORY:	
SOCIAL HISTORY:	
ECOG STATUS:	
BRCA status (ovarian cancer	Date of test: Mainstreaming / Somatic Result:

Surgical details (if applicable)	Please provide the operation report if possible and findings/residual disease)
Chemotherapy/ Radiotherapy details- if applicable	

PATHOLOGY:	Please provide full reports of diagnostic tests, tumour markers, histopathology

IMAGING:	Please provide full reports of USS, CT, MRI, PET CT (as applicable)

For any further assistance, please contact Gynaeoncology Secretary on 02 9382 6290
Fax completed referral to 02 9382 6200. Patients will be triaged within 1 week.

The Royal
HOSPITAL
FOR WOMEN

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