Health
South Eastern Sydney
Local Health District

Facility:

HEREDITARY CANCER CLINIC REFERRAL

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010426

DR KATHY TUCKER **Prince of Wales & St George Hospitals** **Phone: 9382 5100 Fax: 9382 5090**
DR LESLEY ANDREWS **Wollongong & Shoalhaven Hospitals** **Phone: 4222 5706 Fax: 4222 5040**
Email for all hospitals: SESLHD-POWHCC@health.nsw.gov.au

☐ Affected with _____ ☐ URGENT ☐ Interpreter Required
☐ Unaffected ☐ Palliative Language _____

Patient to be seen at:
☐ Prince of Wales Hospital ☐ St George Hospital ☐ The Wollongong Hospital ☐ Shoalhaven Hospital

Purpose of Referral Assessment of family history (describe below)

Gastrointestinal / Gynaecological

	Personal Hx	*FHx
Cancer with **Abnormal Immunohistochemistry (IHC)** Mismatch Repair (MMR) genes	☐	☐
Gastrointestinal Cancer **<50yrs**	☐	☐
Gastrointestinal Cancer **with *FHx**	☐	☐
Diffuse Gastric Cancer **with *FHx** OR with Invasive Lobular Breast Cancer	☐	☐
Lynch Syndrome/ HNPCC	☐	☐
Familial Adenomatous Polyposis (FAP)/ Polyposis _____	☐	☐
Bowel Cancer **AND** Endometrial Cancer	☐	☐
Endometrial Cancer **<60yrs**	☐	☐
Ovarian Cancer **<70yrs**	☐	☐
Rare Gynaecological Cancer	☐	☐

Family Hx** ***(multiple cases with 1 case <60yrs OR ≥ 1 case with high risk feature)

Rare / Other

	Personal Hx	*FHx
Medullary Thyroid Cancer, **any age**	☐	☐
Isolated Retinal Haemangioma **<40yrs**	☐	☐
Isolated CNS Haemangioblastoma **<40yrs**	☐	☐
NET **<40yrs**, or multiple NETs any site, or NET plus a 2nd tumour	☐	☐
Renal Cancer **<45yrs** or **bilateral**	☐	☐
Phaeochromocytoma/Paraganglioma **<50yrs**, or multiple any age	☐	☐
Multiple Primary Cancers ≥ 3 -Discuss with Hereditary Cancer Clinic (HCC); or **two <50yr**	☐	☐
Cancer Predisposing Conditions (eg. NF2, PTEN, RB, VHL, MEN1, MEN2, TP53, NF1) _____	☐	☐
Familial Clustering of Cancer *(type)* _____	☐	☐

^Family History ***(Any FHx)***

Breast / Ovary

	Personal Hx	*Family Hx
Known Breast/Ovarian Cancer Gene _____	☐	☐
Breast Cancer, familial	☐	☐
Breast Cancer **<40yrs**	☐	☐
Triple Negative Breast Cancer **<50yrs**	☐	☐
Bilateral Breast Cancer **<50yrs**	☐	☐
Male Breast Cancer	☐	☐
Breast/Ovary Cancer, Jewish Ancestry, any age	☐	☐
Breast **and** Ovarian Cancer	☐	☐
Ovarian Cancer **<70yrs**	☐	☐
Ovarian Cancer, familial	☐	☐

Family History** ***(multiple cases with 1 case <60yo OR ≥ 1 case with high risk feature)

Other - Management issues / Personal and/or family history / other

Method of contact

1. Is the patient aware of referral? ☐ Yes ☐ No
2. Patient to contact clinic ☐ Yes ☐ Clinic to contact patient

Print Name _____ Provider Number _____

Signature _____ Date _____

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

HEREDITARY CANCER CLINIC REFERRAL
SES010.426

S0924 100417