NSW GOVERNMENT Health
South Eastern Sydney
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

HEREDITARY CANCER CLINIC REFERRAL

SES010426

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Email for all hospitals: SESLHD-POWHCC@health.nsw.gov.au

☐ Affected with _____
☐ Unaffected

☐ URGENT
☐ Palliative

☐ Interpreter Required
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 _____

HEREDITARY CANCER CLINIC REFERRAL SES010.426

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

NO WRITING