# 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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