



Queensland Government

Royal Brisbane and Women's Hospital

QUEENSLAND BREAST CANCER GENETICS CLINIC REFERRAL FORM

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Address:

Contact Number:

Medicare Number:

Date of Birth:

Sex: M F I

Please tick: Dr Julie McGaughran

Complete all sections, sign and fax to: 1300 364 952 (Metro North Central Patient Intake Unit)

Please ensure both pages of referral are faxed

For urgent referrals or clinical queries please contact the on-call team: 07 3646 1686

All patients referred to GHQ must have a valid Medicare card

Patient / family aware of referral Interpreter required Language:

Reason for referral:

Patient diagnosed with breast cancer and: (tick box associated with highest clinical urgency)

Category 1:

- Diagnosed \leq 40 years **and** not yet completed local treatment
 - Diagnosed $<$ 60 years **and** results of genetic testing (if offered) will inform local treatment
 - Diagnosed \geq 60 years **and** personal or close family history of adrenocortical carcinoma, sarcoma or brain tumour **and** may be considered for adjuvant radiation
 - The results of genetic testing (if offered) will inform systemic treatment decisions.
- Specify how:

- Distant metastatic triple negative breast cancer (TNBC)
- Distant metastatic non-TNBC with a short-predicted life expectancy (i.e. weeks) (Telephone 3646 1686 to discuss)

Category 2 (and not fulfilling Cat 1 criteria):

- TNBC or inflammatory with active disease within the last 3 years
- Distant metastatic non-TNBC
- Mainstreamed genetic testing has identified a germline mutation (pathogenic/likely pathogenic variant) in a familial cancer predisposition gene
- Tumour testing has identified a potential germline mutation in a familial cancer predisposition gene
- Untested individual from a family with a known mutation in a familial cancer predisposition gene
- Referral was recommended by GHQ following review of a relative
- Limited life expectancy due to age and/or co-morbidities

Category 3:

- Does not fulfill Cat 1 or 2 criteria.

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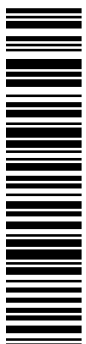
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All clinical form creation and amendments must be conducted through Health Information Services

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Locally Printed



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Date of Birth:

Sex: M F I

Other relevant information:

Planned treatment:

Receiving/planned for adjuvant / neoadjuvant chemotherapy.

Planned completion date: / /

Planned for surgery / further surgery.

Planned date / timeframe and procedure if known:

.....

Planned for adjuvant radiation.

Planned date / timeframe if known:

.....

Relevant pathology reports (histology +/- genetic testing) available at:

Auslab Mater pathology Other:

Genetic testing has been arranged by treating team and results pending.

State laboratory and test ordered:

.....

Other relevant personal or family history:

Genetic Health Queensland Family file number if known: GF

Speciality or GP:

Consultant / GP name:

Consultant / GP provider number:

Contact number:

Address:

Doctor's Name:

Designation:

Signature:

Date: / /

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