Patient label
Name: ________________________________
UR: __________________________________
Date of birth: ________________________

Head and Neck MDM - Expedited oncology referral form

Referral to: *(Tick where appropriate)*

☐ **Radiation Oncology**	**Dr Mori Wada, Dr Richard Khor & Dr Sweet Ping Ng.** Email this referral form to: RADONCREFERRALS@austin.org.au	☐ **Ensure OPG request completed. Date request sent: __/__/____**
☐ **Medical Oncology**	**Prof. Hui Gan** Email this referral form to: medicaloncology@austin.org.au	☐ **Ensure AUDIOLOGY request completed. Date request sent: __/__/____**
☐ **Chemo-radiation**	**Email this referral form to both Radiation Oncology & Medical Oncology & Email patient details to:** OncologyClinicalNurseConsultant@austin.org.au	

Dear Doctor,

Thank you for seeing this patient as discussed in the Austin Health Head and Neck MDM.

MDM date	____ / ____ / 20 ____		
MDM decision (treatment plan)			
Time point *(circle)*	New / Recurrence / Metastatic		
Site of primary			
Date of definitive diagnostic histology	____ / ____ / 20 ____		
AJCC staging – *mandatory** *(circle)*	**T** 1 2 3 4	**N** 0 1 2 3	**M** 0 1
Date of operation (surgical excision)	____ / ____ / 20 ____		
List any significant co-morbidities			
Patient location	**IP** / **OP** *(circle)*	**Location:**	

Please send correspondence back to referring consultant - Name: ________________________

Unit: ________________________

Kind regards,

Referrer name: __________________________

Signature: ________________________________

Provider number: _________________________

Date of referral: ____ / ____ / 20 ____