

<b>FAO – Consultant (if known)</b>		<b>Date</b>
<b>Patient details (sticker)</b> Name: DOB: MRN: Address: Telephone:		<b>Referrer details</b> Consultant: Hospital: Referring clinician: Contact details: Signature:
<b>Patient's current location:</b> <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient – Location:		
<b>Next of Kin Contact Information:</b>		
<b>Diagnosis</b>		
<b>Reason for referral</b> <input type="checkbox"/> Neo-adjuvant RT <input type="checkbox"/> Adjuvant RT <input type="checkbox"/> Definitive RT <input type="checkbox"/> Palliative RT <input type="checkbox"/> Radionuclides		
Previous Radiotherapy: <input type="checkbox"/> No <input type="checkbox"/> Yes Details:		
<b>MDM discussion</b>	Date:	Outcome:
<b>Clinical details</b> (including operation details, endoscopy / histology / imaging / radiology findings with <u>all</u> relevant supporting documentation):		
<b>Significant previous history</b> (including surgery and/or chemotherapy with dates where known):		
<b>Oxygen dependence</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Details:	<b>Communication issues</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Details: <b>Interpreter required</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Details:	<b>Mobility issues</b> <input type="checkbox"/> None <input type="checkbox"/> Chair <input type="checkbox"/> Stretcher
<b>ECOG PS</b> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<b>Infection control issues</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Details:	<b>Pacemaker / ICD</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Details:
<b>Patient known/referred elsewhere:</b> <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Haematology <input type="checkbox"/> Palliative care <input type="checkbox"/> Other Details:		
<b>Send referral by Email (preferred) / Fax / Post</b>		
E-mail: <a href="mailto:Rtreferrals@upmc.ie">Rtreferrals@upmc.ie</a> Fax: 051-337445 Tel: 051-337494 Post: UPMC Hillman Cancer Centre, Butlerstown North, Cork Road, Waterford, X91 DH9W		<b>If this is an urgent/emergency referral (e.g. Spinal Cord Compression) please also contact the RO on call directly via switch</b>
<b>Referrals will not be accepted unless accompanied by <u>all</u> relevant clinical information</b>		