|  |
| --- |
| **Gynaecology Oncology MDM Referral Form** |

# ADHB LOGO colour 30mm clear

# National Women’s Health

**Private Bag 92 189**

**Auckland**

**New Zealand**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral:** |  | **NHI Number:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** |  | **DOB:** |  |
| **Address:** |  |  |  |
| **Phone/Mobile:** |  |  |  |

**High Suspicion of Cancer Treatment Target Date:**

**NB: Please**

* **Refer to page 2 for minimum set of pre-referral investigations**
* **EMAIL completed form to** [**gynaeoncteam@adhb.govt.nz**](mailto:gynaeoncteam@adhb.govt.nz)
* **EMAIL prior to 5pm on Wednesday for following Wednesday meeting**

**All referrals are triaged by a Gynae-Oncologist and will be declined if incomplete**

**REFERRING SPECIALIST**

* Consultant name:
* Hospital/DHB:
* Email address:

**GP name and address:**

**HISTORY**:

* Age:
* Brief history (including relevant examination):
* Co-morbidities:
* Tumour markers (including RMI & required bloods):
* BMI:
* ECOG score:
* Ethnicity:

**RADIOLOGY**:

* Type:
* Date performed:
* Location performed:
* Key findings:
* Type:
* Date performed:
* Location performed:
* Key findings:

**OPERATION:**

* Date:
* Surgeon:
* Procedure:
* Findings:

**HISTOLOGY/CYTOLOGY**

* Specimen type, e.g., pipelle/cervical biopsy:
* Date:
* **Name of the lab:**
* Key findings:

**What is the question for the MDM?**

**Is the patient aware of the CANCER diagnosis?**

**DATE OF DIAGNOSIS:**

**Minimum set of investigations prior to referral:**

|  |  |
| --- | --- |
| **Carcinoma of the Vulva** | * Biopsy result * CT CAP |
| **Carcinoma of the Vagina** | * Biopsy result * FBC, U + E * MRI * PET-CT if curative treatment is being considered * CT CAP if curative treatment is not being considered |
| **Carcinoma of the Cervix** | * Biopsy result * FBC, U + E * Chest x-ray if FIGO 1A or 1B1 or 1B2 * MRI: if cancer histologically proven AND FIGO 1B2 or greater * PET-CT if cancer histologically proven AND FIGO 1B3 or greater, AND curative treatment is being considered * CT CAP if curative treatment is not being considered and 1B3 or greater. |

|  |  |
| --- | --- |
| **Endometrial Carcinoma** | * Histology (pipelle or curettings) * MRI pelvis abdomen and CXR (Grade 1 or 2 endometrioid/ mucinous only) * CT CAP (High grade only e.g. grade 3 endometrioid, serous, clear cell, LVSI, sarcoma etc) |
| **Pelvic Mass** | * CA125, CEA, Ca19-9 * If age < 40 add: AFP, HCG, LDH * For all patients: UEC, LFT, albumin * RMI (risk of malignancy index) score calculated * Abdominal pelvic imaging (CT CAP) for all patients * If age<35 consider replacing CT with MRI +CXR   **Indications for peritoneal deposit/omental cake/metastasis biopsy:**   * Chest disease * Large volume upper abdominal disease * Multiple bowel involvement * Mesenteric involvement * Albumin < 20 * Obstruction * CA 125/CEA ratio < 25   **Mass biopsy is not recommended, unless recommended by MDM** |

**Note 1:** USS for Endometrial Carcinoma and Pelvis Mass may be accepted as an alternative to MRI in exceptional case only (where MRI or CT is not available) with prior agreement with regional service provider.

**Note 2:** Date of diagnosis – confirmed by histology +/- radiology