WA KIRKBRIDE MELANOMA ADVISORY SERVICE
CLINICAL SUMMARY REFERRAL FORM

Patient Details – can use patient label	**Referring Clinician**
NAME Sex	NAME
ADDRESS	ADDRESS
Telephone	Telephone
DOB	Fax

PRIMARY MELANOMA

Anatomic Site…….

Primary excision/biopsy

Laboratory…….....

Date.....

Pathology Report #.....

Re excision

Laboratory…….....

Date……..

Pathology Report #.....

METASTATIC MELANOMA

Lymph Nodes ☐ Skin ☐ Other ☐

Date……

Laboratory…….....

Pathology Report #.....

REASON FOR REFERRAL

Review of Diagnosis ☐ Assessment of Prognosis ☐ Need for re excision ☐

WAKMAS will arrange if requested Y / N

Consideration for Adjuvant Therapy……

Other……

CONSENT TO RELEASE PATHOLOGY

I (Patient's full name)……..DOB……
Hereby authorise: (Please insert relevant laboratory name and address)

To release requested pathology and reports to the WA Kirkbride Melanoma Advisory Service and/or their nominated pathologist

Signature of Patient

……Date……..

PLEASE FAX THIS REFERRAL AND COPIES OF PATHOLOGY REPORTS TO 08 6151 1032
Please phone Nurse Coordinator 08 6151 0860 if you have any queries