

## REFERRAL FORM

 Clinic Appointment

 MDT Discussion

Patient Details – can use patient label		Referring Clinician
NAME <span style="float: right;">Sex</span>		NAME
ADDRESS		ADDRESS
Telephone		Telephone
DOB		Fax

### PRIMARY MELANOMA

#### Primary excision/biopsy

Date.....

#### Re excision

Date.....

Anatomic Site.....

Laboratory.....

Pathology Report #.....

Laboratory.....

Pathology Report #.....

### METASTATIC MELANOMA

Lymph Nodes

Skin

Other

Date.....

Laboratory.....

Pathology Report #.....

### REASON FOR REFERRAL

Pathology Review

Radiology Review

Assessment of Prognosis

Need for: re excision  SNB

Consideration for: Adjuvant Therapy

Clinical Trial

Management Advice

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**Do you want WAKMAS to arrange further management Yes / No**

**Past Medical History/Significant Comorbidities (please provide a list of medications) – attach separate medical summary if preferred.**

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**Relevant Social History**

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**CONSENT FOR YOUR MEDICAL INFORMATION TO BE USED IN FUTURE RESEARCH**

The WA Kirkbride Melanoma Advisory Service is a multidisciplinary clinic that provides advice on the management and care of patients with Melanoma. One of the roles of the clinic is to participate in melanoma research with the aim of improving the outlook for melanoma patients both now and in the future.

An important part of any clinical research may involve collecting medical information on a patient in the future or following their initial treatment and some of this information may be published.

Please take time to read the following, and feel free to discuss this with your doctor.

I \_\_\_\_\_,

agree to give permission for the WA Kirkbride Melanoma Advisory Service to contact my doctor and to review my medical records with respect to melanoma. I understand that it may be necessary to confirm details of my illness or of any treatment I have been given now or in the future.

I understand that the WAKMAS will not pass on any identifiable information about my medical history to any other person or organisation or identify me in any publication. I understand I am under no obligation to give this consent and that I can withdraw my consent at any time.

Signed -----Date-----

Witness-----Date-----

Is the patient aware of diagnosis/referral?    Yes / No

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