WA Kirkbride
MELANOMA ADVISORY SERVICE

REFERRAL FORM

□ Clinic Appointment □ MDT Discussion

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

PRIMARY MELANOMA

Anatomic Site………………………………………

Primary excision/biopsy

Date.......................................

Laboratory…………………………………………........

Pathology Report #...

Re excision

Date……………………………..

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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PATIENT CONSENT FOR MDT DISCUSSION CASES.

The WA Kirkbride Melanoma Advisory Service is a multidisciplinary clinic/team that provides advice on the management and care of patients with Melanoma.
One of the roles of the service 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