**Gynae Oncology M.D.T. Royal Adelaide Hospital Referral Form**

Please complete all fields in order to prevent the referral being rejected by the Referral Management Team. The quality of the information provided will influence when an appointment can be made and if there is insufficient information, a request will be made for a new referral before an appointment is given.

**Date:** Click or tap here to enter text.

**Patient Consent Obtained:** Click or tap here to enter text.

|  |  |
| --- | --- |
| **Referral To:** | **Prof Martin Oehler / Dr John Miller**  **Gynaecology Oncology Department**  **Royal Adelaide Hospital** |
| **Patient Name:** |  |
| **Hospital MRN: (if known)** |  |
| **DOB:** |  |
| **Contact Details:**  Address and phone number |  |
| **Medicare Number & Expiry** |  |
| **GP:**  Full name and clinic |  |
|  | |
| **Reason for Referral:** |  |
| **Question to MDT:** |  |
| **Pathology:**  Please detail and/or attach all relevant reports  (SA Path, Clinpath etc..) |  |
| *SA Pathology request forms x2 to be signed by the referring doctor so that SA Pathology can provide (and bill Medicare for) a formal second opinion on the external/private practice (Clinpath et al) cases.  This will ensure proper documentation of the consensus diagnosis and Investigation pathologist final opinion in our pathology records system and be easily available for future reference. These forms will be emailed on confirmation of referral* | |
| **Radiology:**  Please detail and/or attach all relevant reports  (Benson’s, Dr Jones and Partner’s, Radiology SA etc.. ) |  |
| **History:** | **Past Medical History:**  **BMI:**  **Gynaecology History:** |
| **Medications:** |  |
|  | |
| **Referring Doctor:** | **Name:**  **Provider Number:**  **Address:**  **Email:**  **Contact No:** |

Please submit completed referral via

[Health.CALHNGynaeOncologyReferrals@sa.gov.au](mailto:Health.CALHNGynaeOncologyReferrals@sa.gov.au)