Queensland Private Head & Neck Clinic

# Head and neck patient eMDT referral

eMDT date:

## Referring consultant information

| | | | |
|---|---|---|---|
| First name: | | Last name: | |
| Address: | | | |
| Phone: | | Email: | |
| Provider number: | | Specialty: | |
| GP: | | | |
| Other surgeons involved in care: | | | |

### Nominated person for collection of patient case details

(Please nominate someone our GC eMDT coordinator can contact to collect additional case specific details if required)

| | | | |
|---|---|---|---|
| Name: | | | |
| Phone: | | Email: | |

◯ I confirm that I have:

- advised the patient of the eMDT and my recommendation that I refer their case to the eMDT to formulate a recommended treatment plan
- received express verbal or written consent for the purposes set out in the GenesisCare information sheet for patients, which is recorded in my notes. I understand that I may have to verify to GenesisCare that this consent was obtained
- provided to the patient a copy of the GenesisCare information sheet on eMDTs

## Patient information

| | | | | | |
|---|---|---|---|---|---|
| First name: | | | Last name: | | |
| Unique patient identifier (if applicable): | | | | | |
| Address: | | | | | |
| Date of birth: | | Gender: ◯ Male ◯ Female | | Medicare number: | |
| Next of kin: | | | | | |
| Next of kin contact details: | | | | | |



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## Head and neck patient case information

| | | | | | |
|---|---|---|---|---|---|
| **Clinical case summary** (including treatments to date) | | | | | |
| | | | | | |
| **Clincial question** (please indicate specific issue you would like reviewed or clinical decision that needs to be addressed) | | | | | |
| | | | | | |
| Additional comments | | | | | |
| | | | | | |
| ECOG status: | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 | ◯ 4 |
| Co-morbidities: | | | | | |
| Immunosuppressed? | ◯ Yes | ◯ No | | | |
| Diagnosis: | | Date of biopsy confirming diagnosis: | | | |
| Stage: | | | | | |
| p16 status: | ◯ + | ◯ - | ◯ N/A | | |
| Provisional TNM stage (AJCC 8): | | | | | |

## Please complete for all patients

| | | | | |
|---|---|---|---|---|
| Smoking status: | ◯ Current smoker | ◯ Past smoker | ◯ Never smoked | Pd/no. years: |
| Alcohol consumption (g/day): | | | | |
| Loss of weight (LOW) (kg): | | | | |
| Medications: | | | | |
| Allergies: | | | | |

## Please also complete the section below for post operative patients

| | | |
|---|---|---|
| Date of surgery: | | |
| Surgery description: | | |

## Please include along with this referral form

| | | | | |
|---|---|---|---|---|
| Have you included the pathology report? | ◯ Yes | ◯ No | | |
| Pathology provider: | | Pathology date: | | |
| Have you included relevant radiology report? | ◯ Yes | ◯ No | | |
| Radiology provider: | | Radiology dates: | | |
| **Imaging performed** (Please include provider and dates if ticked) | | | | |
| ◯ Contrast CT | | | | |
| ◯ PET CT | | | | |
| ◯ MRI | | | | |
| ◯ OPG | | | | |
| ◯ Other | | | | |
| ◯ Video from Nasendoscopy | ◯ Photographs provided | | | |



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