Referral for non-urgent genetic assessment to Parkville Familial Cancer Centre

Professor Paul James /Associate Professor Alison Trainer

Referring Clinician: _____

Provider Number: _____

Department & Hospital/Clinic: _____

Patient details or UR sticker:

Name: _____ Date of Birth: _____

Mobile: _____ Home:_____

Address: _____

Email: _____

Please refer patients meeting the Parkville Familial Cancer Centre referral guidelines (https://www.thermh.org.au/services/genetic-medicine/parkville-familial-cancer-centre)

Details of personal/family history or cancer *(essential for triage)*
(site of primary cancers, age of diagnoses, relationship to patient, pathology information if known)

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_____

Genetic assessment required to inform treatment? → **Please provide details and timeline above**

☐ **Histopathology report attached**
(essential for personal history cancer)

☐ **I have discussed this referral with the patient**
(essential)

☐ Short term prognosis uncertain *(FCC to consider DNA storage)*

Signature: _____ **Date:** _____

Send forms to: **Fax:** 03 9342 4267 **Email:** familycancer@mh.org.au
Tel: 03 9342 7151 **Web:** www.thermh.org.au