

INTER HOSPITAL CONSULTANT REFERRAL FORM

NATIONAL SURGICAL CENTRE FOR PANCREATIC CANCER

POST or FAX this FORM and send essential **DIAGNOSTIC** requirements to the
Clinical Nurse Specialist, National Surgical Centre for Pancreatic Cancer, St Vincent's University Hospital, Elm Park, Donnybrook, Dublin 4.
Tel: (01) 221 3767 or (01) 221 4000 bleep 648 **Fax:** (01) 221 3601

Patient Details	
Surname: _____	
First Name: _____	DOB: _____
Address: _____ _____	
Mobile No: _____	Tel day: _____
Tel evening: _____	
Hospital No. (if known): _____	
First language: _____	Interpreter required: Yes <input type="checkbox"/> No <input type="checkbox"/>
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Wheelchair assistance: Yes <input type="checkbox"/> No <input type="checkbox"/>

Referring Consultant Details	
Name: _____	
Hospital: _____	
Address: _____ _____	
Telephone: _____	Mobile: _____
Fax: _____	
Consultant Signature: _____	
Medical Council Registration No.: _____	

PROVISIONAL DIAGNOSIS:

Has patient been informed of diagnosis? Yes No Date of first attendance: _____

PRESENTING SYMPTOMS

<input type="checkbox"/> Abdominal Mass	<input type="checkbox"/> Dark Urine / Pale Stools	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Anaemia	<input type="checkbox"/> Dyspepsia	<input type="checkbox"/> Nausea / Vomiting	<input type="checkbox"/> Pruritus
<input type="checkbox"/> Pain <i>Please specify site and type:</i> _____			
<input type="checkbox"/> Other <i>Please specify:</i> _____			

PANCREATIC / LIVER DISEASE

Does patient suffer from pancreatitis? Yes No

History of diabetes? Yes No

Does patient have pre-existing liver disease? Yes No *If yes please specify:* _____

DIAGNOSTICS *(please include appropriate reports)* Previewing Radiologist: _____ HSE Network: _____

CD-ROM forwarded: Yes <input type="checkbox"/> No <input type="checkbox"/>	Minimum diagnostics required: <input type="checkbox"/> CT pancreatic protocol	Additional radiology (if appropriate)	<input type="checkbox"/> Octreotide scan
Date forwarded: _____	<input type="checkbox"/> Biopsy	<input type="checkbox"/> MIBG scan	<input type="checkbox"/> PET / CT
Reports forwarded: Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> MRI	<input type="checkbox"/> Cholangiography (MRCP, ERCP or PTC)	<input type="checkbox"/> Endoscopic ultrasound +/- biliary stent insertion.

HISTOLOGY Yes No

Reports & slides forwarded to: Consultant Histopathologist for Pancreatic Cancer, Histopathology office, SVUH, Dublin 4. Yes No

<p>PAST MEDICAL HISTORY:</p> <p>Anticoagulants: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Comments:</p>
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FOR HOSPITAL USE:	
Date referral received: _____	
Patient listed for MDT discussion: Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes Date: _____ If no please specify: _____
OPD appointment offered: Yes <input type="checkbox"/> No <input type="checkbox"/>	OPD date and time: _____
Completed by: _____	Date: _____