Breast Cancer Clinical Trials Unit (BCTU)
Suite 407, Hollywood Consulting Centre
F 6500 5577
T 6500 5575
EDI breastci **I ADDRESSEE** Clinical Trials

breast cancer research centre-wa
incorporating Perth Breast Cancer Institute

Clinical Trials Referral Form

Please complete the form below to refer a patient to a clinical trial with Dr Hilary Martin, Dr Peter Lau or Dr Louisa Lo. If precise dates are unknown, please give approximate dates where possible. Download and return securely via Healthlink **breastci** or fax to **6500 5577**.

Patient details

First Name:

Last Name:

Home Phone:

Mobile Phone:

Date of Birth:

Email:

Address:

Medicare: ☐ Yes ☐ No

Does the patient have private health cover: ☐ Yes ☐ No

Disease and Treatment details

Current stage of Disease: ☐ Early ☐ Metastatic ☐ Inoperable locally advanced

Date of Diagnosis of Early Stage Breast Cancer:

Neoadjuvant Therapy Received: ☐ Yes ☐ No

Treatment Received*	Start Date	End Date

Adjuvant Therapy Received: ☐ Yes ☐ No

Treatment Received*	Start Date	End Date

Date of Diagnosis of Metastatic Disease:

Metastatic Therapy Received: ☐ Yes ☐ No

Treatment Received*	Start Date	End Date

Referral Narrative

Please include any relevant patient information such as whether patient wants to be seen for general trial discussion or whether specific trial is reason for referral. Additional information of relevance such as additional lines of therapy in metastatic setting, and whether patient referral is for a specific trial.

Supporting Documentation

Histology and radiology reports are essential for assessing trial eligibility for patients and their provision will enable efficient assessment of patients.

Histology

For histology we request the most recent histology report from biopsy or surgery as well as previous available histology reports such as diagnostic core biopsy and final surgical pathology. Please send these reports through along with the referral.

Details of previous histology samples and provider:

Radiology

For radiology we request the most recent imaging reports. Please send these reports through along with the referral.

Details of recent radiology including any CNS imaging, PET scan and provider:

Referrer Details

First Name:

Last Name:

Best Contact Number:

Email:

Provider Number:

Signature:

Date: