

Gamma Knife[®] Centre of Queensland at the Princess Alexandra Hospital

Malignant Conditions/Brain Mets

Patient Details			
Full Name:		DOB	___/___/___
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Hospital #	
Patient Address:		Home ph:	
		Mobile ph:	
Named Referral to: <input type="checkbox"/> Dr Matthew Foote <input type="checkbox"/> Dr Mark Pinkham <input type="checkbox"/> Dr Michael Huo <input type="checkbox"/> Dr Bruce Hall <input type="checkbox"/> Dr Sarah Olson			
Brain Metastasis History			
Date Diagnosed: ___/___/___		Date of most recent EC Staging: ___/___/___	
Date of most recent MRI: ___/___/___	Location (Imaging Centre): <small>(Please attach images and reports to referral where possible)</small>		
Current Symptoms:	ECOG:	Number of Mets: Are they all <3cm across? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Has WBRT been given: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: ___/___/___ Dose/Fractionation: _____			
Dexamethasone dose (if app):			
Cancer History			
Primary Site:		Histological type:	
Primary Treatment Details:			
Systemic Disease: <input type="checkbox"/> Absent <input type="checkbox"/> Present → Prognosis greater than 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
General History			
Past Medical History:		Previous Treatment &/Or relevant medication:	
Referral Details			
Referring Consultant:		Contact ph:	
Signature:		Referring hospital:	
Date of referral: ___/___/___		Provider #	
Please complete referral form and fax to the Central Referral Hub on 07 3176 2859 Please include copies of all relevant histology reports and medical imaging transferred to the PAH. Please note that failure to provide all the information requested may delay the processing of your referral.			