# GenesisCare Patient Skin MDT Referral

## All requests to MDT coordinator:

Maxine Smith E: oncologywamdt@genesiscare.com

# **Referring doctor information**

Phone:  Specialty:  Other doctors involved in care:  Provider number:  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  Patient information  *First name:  Unique patient identifier (if applicable):  *Date of birth:  *Gender: Male Female Medicare number:				ı	1		
Phone:  Specialty:  Other doctors involved in care:  Provider number:  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  Patient information  *First name:  Unique patient identifier (if applicable):  *Date of birth:  *Gender:  *Gender:  *Male  Female  Medicare number:  *Required finit	*First name:			*Last name:			
Specialty:  Other doctors involved in care:  Provider number:  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  Patient information  *First name:  Unique patient identifier (if applicable):  *Date of birth:  *Gender: Male Female Medicare number:  *Required flet  *Inical information  Clinical case summary & questions (basic information, specifics for discussion, date of relevant surgery)  Please include along with this referral form  Have you included the pathology report?  Yes No  *Pathology provider:  *Pathology provider:	Address:						
Other doctors involved in care:  Provider number:  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  Patient information  *First name:  Unique patient identifier (if applicable):  *Date of birth:  *Gender: Male Female Medicare number:  *Required field  Clinical information  Clinical case summary & questions (basic information, specifics for discussion, date of relevant surgery)  Please include along with this referral form  Have you included the pathology report?  Yes No  *Pathology provider:  *Pathology date:	Phone:			*Email:			
involved in care:  Provider number:  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  Patient information  *First name:  Unique patient identifier (if applicable):  *Date of birth:  *Gender: Male Female Medicare number:  Takequired field  Clinical information  Clinical case summary & questions (basic information, specifics for discussion, date of relevant surgery)  Please include along with this referral form  Have you included the pathology report?  Yes No  *Pathology provider:  *Pathology provider:	Specialty:			,			
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  Patient information  *First name:  Unique patient identifier (if applicable):  *Date of birth:  *Gender: Male Female Medicare number:  *Required field  Treatment information  Clinical information  Clinical case summary & questions (basic information, specifics for discussion, date of relevant surgery)  Please include along with this referral form  Have you included the pathology report?  Yes No  *Pathology provider:  *Pathology provider:  *Pathology provider:  *Pathology provider:  *Pathology provider:  *Pathology provider:	Other doctors involved in care:						
advised the patient of the eMDT and my recommendation that I refer their case to the eMDT to formulate a recommended treatment plan  Patient information  *First name:  Unique patient identifier (if applicable):  *Date of birth:  *Gender: Male Female Medicare number:  *Required field  Clinical information  Clinical case summary & questions (basic information, specifics for discussion, date of relevant surgery)  Please include along with this referral form  Have you included the pathology report?  Yes  No  *Pathology provider:  *Pathology provider:	Provider number:		Signature:				
Unique patient identifier (if applicable):  *Date of birth:  *Gender: Male Female Medicare number:  *Required field  *Require	advised the pa treatment plan	tient of the eMDT and my	recommendation	on that I refer th	neir case t	to the eMDT to form	ulate a recommended
*Date of birth:  *Gender: Male Female Medicare number:  *Required field  *	*First name:			*Last name:			
Clinical information Clinical case summary & questions (basic information, specifics for discussion, date of relevant surgery)  Please include along with this referral form  Have you included the pathology report? Yes No  *Pathology provider:  *Pathology date:	Unique patient identi	fier (if applicable):					
Clinical information  Clinical case summary & questions (basic information, specifics for discussion, date of relevant surgery)  Please include along with this referral form  Have you included the pathology report? Yes No  *Pathology provider: *Pathology date:	*Date of birth:		*Gender: M	1ale Fema	le <b>Me</b> c	dicare number:	
Clinical case summary & questions (basic information, specifics for discussion, date of relevant surgery)  Please include along with this referral form  Have you included the pathology report?  Yes  No  *Pathology provider:							*Required field
Please include along with this referral form  Have you included the pathology report? Yes No  *Pathology provider: *Pathology date:	Clinical informat	ion					
Have you included the pathology report?  Yes  No  *Pathology provider:  *Pathology date:	Clinical case summar	<b>ry &amp; questions</b> (basic info	rmation, specific	cs for discussio	n, date of	relevant surgery)	
Have you included the pathology report?  Yes  No  *Pathology provider:  *Pathology date:	Please include al	ong with this refer	ral form				
				1	No		
Have you included relevant clinical photos? Yes (please attach to this form) No	*Pathology provider:					*Pathology date:	
	Have you included re	levant clinical photos?	Yes (please	attach to this form	) No	,	



# This is a referral for:

#### A. Treatment of localised skin cancers

- (P) Primary treatment (in place of surgery or other treatments)
  (S) Secondary treatment (adjunctive to surgery or other treatments)

P/S	Cancer type	Cancers identified (see right)	New or recurring	Previous treatments
PO SO				
P O				
PO SO				

## B. Regional skin cancers

Cancer type	Cancers identified (see right)	New or recurring	Previous treatments

Fitzpatrick skin phototype						
$\bigcirc$	$\bigcirc$	$\bigcirc$	$\bigcirc$	$\bigcirc$	$\bigcirc$	
Very fair	Fair	Medium	Olive	Brown	Black	
Always burns,	Usually burns,	Sometimes burns,	Rarely burns,	Never burns,	Never burns,	
cannot tan	sometimes tans	usually tans	always tans	always tans	always tans	

Votes	(relevant	medical	history/	current	medications,	relevant/	comorbidities)





