Austin Health

Hepatocellular Carcinoma Referral Form

Surname ……

Given Name(s) ……..

Date of Birth..……..…….

In addition to the form below, please also include referral letter. ☐ (Check box to confirm attached)

Please fully complete **all sections** of this form. Please attach any supporting documents (imaging reports, pathology, correspondence) and mail/email to the address below.

Imaging:

Please provide all baseline imaging and complete below:

☐ CT Scan Date/s: ____ Sending disk with referral **OR** Where were images done? _____
(Circle appropriate)

☐ MRI Liver/MRCP Date/s: ____ Sending disk with referral **OR** Where were images done? _____
(Circle appropriate)

Lesion detected via – please tick

☐ Screening ☐ Incidental finding ☐ Symptomatic – weight loss/pain

☐ Histology: Date _____ Location _____

Pathology:

Please provide all baseline pathology information below.
Please fax relevant copies with referral.

Date of bloods: _____ Where were bloods done _____

Date of bloods: _____ Where were bloods done _____

Clinical details – please tick/circle

Ascites: ☐ Absent ☐ Easily controlled ☐ Difficult to control

Encephalopathy: Yes/No

Prior treatment – please tick

☐ TACE - Date/s _____ Medical centre _____
☐ RFA - Date/s _____ Medical centre _____
☐ Resection - Date/s _____ Medical centre _____
☐ PEI - Date/s _____ Medical centre _____
☐ Clinical Trial – Date/s _____ Medical centre _____
☐ Systemic Therapy – Date/s _____ Medical centre _____
☐ SIRTEX – Date/s _____ Medical centre _____
☐ Other – Date/s _____ Medical centre _____

Please send to:
Attention HCC Nurse, Liver Transplant Unit, PO Box 5555 Heidelberg Vic 3084
Fax: 9496 3487 or hepatoma@austin.org.au