ncсp National Cancer Control Programme

Sláinte Leanaí Éireann CHI Children's Health Ireland

National AYA Cancer Service MDM Referral Form

Patient Details					
Given Name		**Family Name**		**D.O.B.**	
MRN		Sex at Birth	Male Female	Age	
Address		Twin	Yes No	Patient consent for AYA MDM referral	Yes No
		Ethnicity			
		Postcode			

Referrer Details			
Referral Type	*e.g. new diagnosis, EOT, case review, death*	Referral Date	
Referring consultant		Principal treatment centre	
CNS		GP Name (& address)	
Contact # (MDT presenter)			

Cancer Details					
Diagnosis		Stage/Grade		Est. date of symptom onset	
Primary site		Prognostic Score (& system used)		Est. date 1st presented to primary care	
Metastatic sites		Tumour Markers		Est. date 1st seen by cancer services	
Morphology (if relevant)		Treatment Intent *e.g. curative, palliative, other*		Diagnosis date	
Investigations				Treatment start date	
Treatment Plan				Anticipated EOT date	
Palliative Care	Palliative Care Needs assessment performed?	Yes No	Palliative Care referral sent?	Yes No	
Outcome of local MDT				Local MDT Date	

Clinical Information	
Presenting history	*Please include comment on diagnostic pathway with dates / involved specialties where relevant*
Co-morbidities and past medical history	*Please include comment on additional health issues which may impact on therapy*
Relevant family history	

Contact: Email (referral submission/queries): ayamdm@healthmail.ie AYA MDM phone: 087 1999 013

Additional forms can be downloaded via: https://bit.ly/AYAreferral

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Clinical Trials			
Clinical trial available?	Yes No	Name of Trial	
Eligible	Yes No	If 'no', please specify reason	
Offered	Yes No	Consented	Yes No

Fertility Issues			
Fertility discussed & documented	Yes No	*If 'no' please provide comment on reasons*	
Fertility preservation undertaken	Yes No	*If 'yes' – which type of fertility preservation*	
		If none undertaken please provide comment on reasons	

Psychosocial status/support		*The AYA service recommends the HEEADSSS assessment tool*
Health Needs Assessment status:		For further guidance on performing a HEEADSSS assessment: https://starship.org.nz/guidelines/adolescent-consultation/

Quick guide to HEEADSSS Assessment

HOME
Who lives at home with you? How do you get along with your parents/siblings?

EDUCATION & EMPLOYMENT
Are you working? How do you get along with peers/colleagues? What school/college do you go to?

ACTIVITIES
What do you do for fun/downtime? What do you do with friends?

DRUGS
When you go out with friends do some people you hang out with drink, smoke, vape or take drugs?

SEXUALITY
Are you in a relationship? How would you describe yourself in terms of sexual preference? Are you sexually active?

SUICIDE & DEPRESSION
Are you an anxious person? How are you coping? Do you ever suffer with low mood or sleep disturbances?

SAFETY
Is there anyone in your life that you don't feel safe around?

Significant areas for discussion:		
AHP referrals required	Yes Required *(but unavailable)* No Patient declined	*If "yes" please indicate which teams involved:* Physiotherapy Dietician OT MSW Other (e.g. community services):
Psycho-oncology input required	Yes Required *(but unavailable)* No Patient declined	*If "yes, required" please select which team is required:*

Discussion points for MDM

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