**Locally advanced, inoperable\* or Metastatic Breast Cancer**

**Referral for Palliative Radiotherapy**

**Please Note: We do not need a separate referral letter but enclosing any correspondence to GP/patient is helpful**

\* inoperable = surgery will not ever be possible

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| **Details of referrer**  Name of Surgeon: Click here to enter text. |

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| **Patient Details**  Name: Click here to enter text.  DOB: Click here to enter text.  NHS No: Click here to enter text. |

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| **Referral category must be completed below** | **Yes** | | | **No** | | **N/A** |
| Please state which breast tumour type. | | | | | | |
| 1. Her-2 Positive Pathway (ER any) |  | | |  | |  |
| 1. Triple Negative Pathway (ER 4 or less) |  | | |  | |  |
| 1. Hormone Receptor Positive Pathway (Her-2 negative) |  | | |  | |  |
| Has a biopsy of a metastatic site been done? |  | | |  | |  |
| Is a biopsy of a metastatic site planned? |  | | |  | |  |
| Has the patient been sent for genetic testing |  | | |  | |  |
| Please state which area a palliative radiotherapy referral is for (eg brain, spine):  NB: There is a separate referral route for urgent radiotherapy for cord compression | | | | | | |
| Please state any outstanding investigations: | | | | | | |
| Does the patient require an interpreter? | |  |  | |  | |
| If yes, please confirm which language: | | | | | | |
| Please confirm that the patient has also been referred for systemic therapy: | |  |  | |  | |

**Continue to next page…**

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| Additional information  e.g. relevant information to prioritise urgency - visceral crisis etc: |
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| **Minimum Dataset**  **(Clinician please state what is available/ planned for the administrator to attach)** | **Yes** | **No** | **N/A** |
| 1. Biopsy report of metastatic site:   All available histopathology reports (including ER,PR and Her2 and any previous breast pathology reports) |  |  |  |
| 1. Core biopsy report (from current or historical breast cancer diagnosis): histopathology (including ER PR and Her2 status) |  |  |  |
| 1. Breast surgical histopathology (from current or historical breast cancer diagnosis) |  |  |  |
| 1. CT TAP scan report (if report available in SECTRA – do not attach) |  |  |  |
| 1. MR report |  |  |  |
| If MR done, please state which area(s) (e.g. head, spine, liver): |  | | |
| 1. PET-CT report |  |  |  |

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| **Planned Breast MDT Discussion Date:**  (Please note: patients with metastatic cancer can be referred ahead of MDT but please ensure every case is discussed at the MDT) |
| **Additional comments (e.g. significant co-morbidities):** |