Health
Western Sydney
Local Health District

Liver MDT Referral Form

Clear Form

Please **complete all sections** of this form. The information will assist us to appropriately triage your patient. Referral form must be in ***by 1300hrs Thursday.*** Only CT or MRI images will be reviewed.

For all enquires please contact: HCC Clinical Nurse Consultant, Storr Liver Centre, at Westmead Hospital.

Phone: (02) 8890 7705 Mobile: 0400 393 360 Fax: (02) 8890 3678 Email: **WSLHD-LiverMDM@health.nsw.gov.au**

Referral Pathway

Referral Date: Westmead Hospital: Please select Blacktown Hospital: Please select

☐ Private Consulting Rooms ☐ Radiation Oncology ☐ UGIT Surgeon ☐ Screening

Other: Lead Clinician: Prof Jacob George

Patient Information or Sticker Label

MRN		Surname		First Name		Interpreter required	☐
Gender	☐ Male ☐ Female	DOB		Best contact number		Patient notified of referral	☐

Primary Liver Disease

☐ ETOH ☐ NASH ☐ HCV ☐ HBV ☐ PBC ☐ PSC ☐ Other

Relevant Medical History

Essential Requirement – Please complete below. Please write lab results.

Clear Section

Date (dd/mm/yyyy)	Bilirubin	Creat	Na+	AFP	INR	Platelets	ALT	Albumin

Child Pugh Score	0	**Class**	
Encephalopathy		Bilirubin (umol/L)	
Ascites		Albumin (g/dL)	
INR			

ECOG Please Select

Imaging Provider

Clear Section

Imaging	☐ CT	☐ MRI/MRCP	Other				
Location	☐ Westmead Hospital	☐ Blacktown Hospital	☐ Castlereagh Imaging	☐ PRP	☐ I-Med	Other	
Date							

Clinical Question to be Addressed by MDT

Referrer Details

Name		Phone Number		Fax Number	
Provider Number		Address			

If Specialist Referring Please Provide GP Details

Name		Phone Number		Fax Number	
Address					

Save Form Submit Form Print Form

OR

Save the completed PDF and send as attachment to: WSLHD-LiverMDM@health.nsw.gov.au