National AYA Cancer Service MDM Referral Form

You should refer any AYA with cancer under your care as per the NCCP to ensure your AYA patients benefit from specialist oversight, enhanced support, and access to national resources tailored to their unique developmental needs. (Link to NCCP AYA Cancer website for further information).

We encourage you to refer to register the AYA for data collection purposes even if they do not need a full MDM discussion - In this case select 'Registration Only' under 'Purpose of Referral' & complete indicated boxes only.

Clinical governance remains with the referring team.

Referrals are welcomed from any location across the country. Any health professional who is treating an AYA with cancer can make a referral, or request to attend the MDM.

Referrer Details			Complete for MDM & Registration
Referral Date		Consultant aware of referral	◯ Y ◉ N
MDM Day Preference *(optional)*	☐ Tues ☐ Wed	MDM Date Request	
Priority	◯ Routine ◯ Urgent		
Purpose of referral	Select from dropdown:		
Clinical question for the MDM			
Request MDM review (*optional*):	☐ Pathology ☐ Radiology		
Principal treatment centre		Shared Care Centre (*if relevant*)	
Consultant		CNS	
Who will present at the MDM		Contact email (*presenter*)	

Who also needs to attend this MDM? *Please include name/email*	Complete for MDM Only
Suggesting invitees: members of local treating team; shared cared team; team for referred procedures such as BMT or RT; Allied Health such as Psychology, MSW, OT	

GP Details *Please include name, practice & location*	Complete for MDM Only
The GP will be invited to the MDM & receive a copy of the MDM outcome letter	

Email (referral submission/queries): ayamdm@healthmail.ie
Additional forms: https://bit.ly/AYAreferral

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Patient Details					Complete for MDM & Registration
Given Name		Family Name		D.O.B.	
Local MRN		IHI (*if known*)			
Gender	◯ Female ◉ Male	Ethnicity		Select:	
Address					

Clinical Details					Complete for MDM & Registration
Diagnosis				Date of Diagnosis	
Primary site		Stage/Grade		Treatment Intent	Select:
Relevant clinical details	*Include as relevant: morphology, tumour markers, prognostic score, metastatic sites*				
Presenting history & investigations *(summary only)*					
Comorbidities & Prior History					
Relevant family medical history					
Site-specific or local MDM outcome				Local MDM Date	
Treatment Plan					
Treatment Start Date				Anticipated EOT Date	

Palliative Care				Complete for MDM & Registration
Is Palliative Care Required?	◯ Yes	◯ No	◯ Unsure	
Comment (*optional*):				

Fertility					Complete for MDM & Registration
Fertility discussed & documented?	◯ Yes	◯ No	◯ Unsure		
Preservation completed?	☐ Yes	☐ No	Type:	Select:	
Comment (*optional*):					

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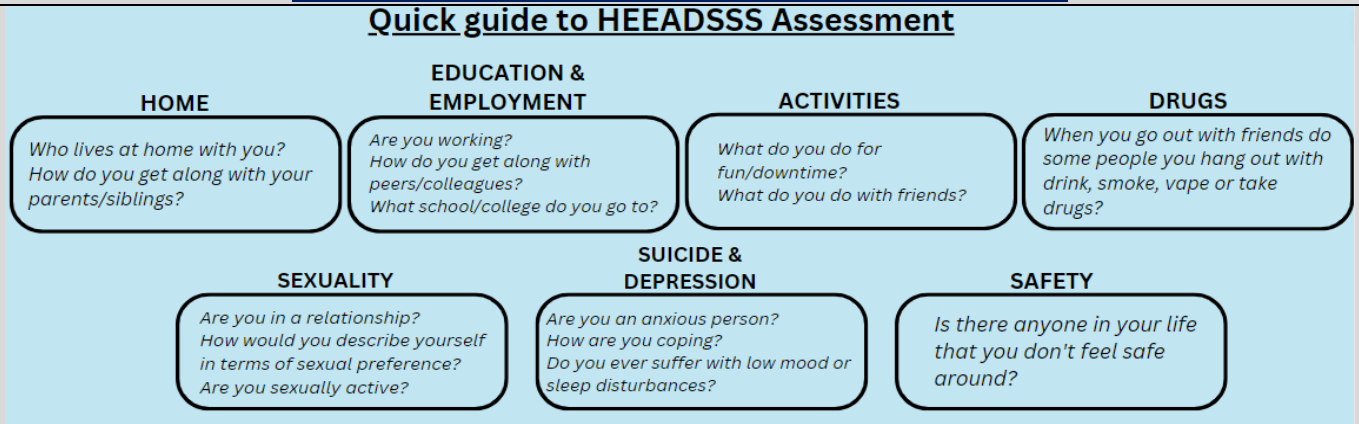
Clinical Trials	Complete for MDM & Registration
On a clinical trial?	◯ Yes ◯ No ◯ Unsure
If yes, name of trial:	

Psychosocial Status/Support	Complete for MDM Only

The AYA service recommends the HEEADSSS assessment tool

For further guidance on performing a HEEADSSS assessment:
https://starship.org.nz/guidelines/adolescent-consultation/



Has a Health Needs Assessment been performed?	◯ Yes ◯ No ◯ In progress
Significant areas for discussion:	

Allied Health Referrals	Complete for MDM & Registration
Which AHP referrals have been made?	☐ MSW ☐ Physio ☐ OT ☐ Dietician ☐ Other: _____
Comment (*optional*):	

Psycho-Oncology Referral	Complete for MDM & Registration
Has AYA been referred to psycho-oncology?	◯ Yes ◯ No ◯ Unavailable ◉ Unsure
Comment (*optional*):	

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