Neoplasia of the Testis - Retroperitoneal Lymphadenectomy Request Information

Family name

Given name(s)

Date of birth

DD – MM – YYYY

Date of request

DD – MM – YYYY

Indigenous Status

- ○ Aboriginal but not Torres Strait Islander origin
- ○ Torres Strait Islander but not Aboriginal origin
- ○ Both Aboriginal and Torres Strait Islander origin
- ○ Neither Aboriginal nor Torres Strait Islander origin
- ○ Not stated/inadequately described

Patient identifiers
e.g. MRN, IHI or NHI (please indicate which)

Requesting doctor - name and contact details

Copy to doctor
name and contact details

CLINICAL INFORMATION

☐ Previous history of testicular cancer *(specify)*

☐ Previous therapy *(specify)*

☐ Other *(specify)*

PRE-PROCEDURE SERUM TUMOUR MARKERS
(select all that apply)

☐ Serum tumour markers within normal limits
OR

Specify serum tumour markers used, level and date markers were drawn

Date

☐ LDH IU/L

☐ AFP ug/L

☐ b-HcG IU/L

PRINCIPAL CLINICIAN

OTHER COMMENT