Hepatocellular Carcinoma Referral Guidelines

Austin Health Hepatocellular Carcinoma unit holds weekly multidisciplinary sessions to discuss and plan the treatment of patients with possible Hepatocellular Carcinoma conditions.

Department of Health clinical urgency categories for specialist clinics
Urgent: Referrals should be categorised as urgent if the patient has a condition that has the potential to deteriorate quickly, with significant consequences for health and quality of life, if not managed promptly. These patients should be seen **within 30 days** of referral receipt. For emergency cases please send the patient to the Emergency department.
Routine: Referrals should be categorised as routine if the patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if specialist assessment is delayed beyond one month.
Exclusions: Uncomplicated CT proven diverticulitis without suspicious features (e.g. unusual location), Routine surveillance & follow up colonoscopy for patients in the care of another health service, Single symptoms – **abdominal pain, constipation**, Low ferritin with normal Hb, Acute diarrhoea <6 weeks, Adenocarcinoma unknown primary without colonic symptoms, Bright rectal bleeding (likely anal/rectal cause) <50 (these patients should be referred for a flexible sigmoidoscopy).

Condition / Symptom	**GP Management**	**Investigations Required Prior to Referral**	**Expected Triage Outcome**	**Expected Specialist Intervention Outcome**	**Expected number of Specialist Appointments**
Hepatocellular carcinoma (HCC)	Complete investigations as per referral form. Please provide details of GP and/or other doctors within referral letter.	See referral form for full details - Clinical history and examination - Imaging: Quad phase CT Liver and/or MRI Liver to be performed prior to referral - Diagnostics: FBE, U&E, LFT, INR, AFP Please ensure either a hard copy of imaging or information regarding when and where imaging was completed accompanies the referral (as per referral form)	**Urgent:** To be seen within 30 days of complete referral received by unit	As required	**Hepatocellular carcinoma (HCC)**

Austin Health

Hepatocellular Carcinoma Referral Form

Surname ……

Given Name(s) ……..

Date of Birth..……..…….

In addition to the form below, please also include referral letter. ☐ (Check box to confirm attached)

Please fully complete **all sections** of this form. Please attach any supporting documents (imaging reports, pathology, correspondence) and mail/email to the address below.

Imaging:

Please provide all baseline imaging and complete below:

☐ CT Scan Date/s: ____ Sending disk with referral **OR** Where were images done? _____
(Circle appropriate)

☐ MRI Liver/MRCP Date/s: ____ Sending disk with referral **OR** Where were images done? _____
(Circle appropriate)

Lesion detected via – please tick

☐ Screening ☐ Incidental finding ☐ Symptomatic – weight loss/pain

☐ Histology: Date _____ Location _____

Pathology:

Please provide all baseline pathology information below.
Please fax relevant copies with referral.

Date of bloods: _____ Where were bloods done _____

Date of bloods: _____ Where were bloods done _____

Clinical details – please tick/circle

Ascites: ☐ Absent ☐ Easily controlled ☐ Difficult to control

Encephalopathy: Yes/No

Prior treatment – please tick

☐ TACE - Date/s _____ Medical centre _____
☐ RFA - Date/s _____ Medical centre _____
☐ Resection - Date/s _____ Medical centre _____
☐ PEI - Date/s _____ Medical centre _____
☐ Clinical Trial – Date/s _____ Medical centre _____
☐ Systemic Therapy – Date/s _____ Medical centre _____
☐ SIRTEX – Date/s _____ Medical centre _____
☐ Other – Date/s _____ Medical centre _____

Please send to:
Attention HCC Nurse, Liver Transplant Unit, PO Box 5555 Heidelberg Vic 3084
Fax: 9496 3487 or hepatoma@austin.org.au