Pathology Discussion Sheet

Post-treatment breast cancer survivorship · prepared by the patient for discussion

Patient	Date	Seen by	Oncologist / GP
_____	_____	_____	_____

I am a breast cancer survivor undertaking a structured daily exercise programme and I would like to establish a baseline and retest at 30, 60 and 90 days. I have grouped these by how clinically justifiable I understand them to be, so we can work through them quickly. I am not asking for all of them. Please order only what you consider appropriate, decline anything that is not, and I will arrange the rest privately if I choose to. If it is easier to split the request across more than one appointment, that is completely fine.

MY CONTEXT

BRCA1 carrier · triple negative breast cancer · surgery, chemotherapy and radiation completed · lymph nodes removed · _____ years post-treatment

Risk-reducing surgery: _____ Current medication: _____ Menopausal status: _____

GROUP 1 · ROUTINE SURVEILLANCE AND STANDARD WORKUP

These are the ones I would most like, and I believe the most straightforward to justify. If we only get through one group, this is the one that matters.

TEST	WHY I AM ASKING	YES	NO	NOTE
hs-CRP	Systemic inflammation. The single marker I most want to track across the 90 days.			
FBE / FBC	Post-chemotherapy haematological recovery, lymphocyte count.			
ESR	Inflammation, alongside hs-CRP.			
LFTs	Liver function after months of cytotoxic therapy.			
UEC	Renal function and electrolytes, baseline before a daily exercise programme.			
HbA1c + fasting glucose	Metabolic baseline. Weight change and steroid exposure during treatment.			
Fasting lipids	Aromatase inhibitors can cause small elevations in cholesterol, and an annual lipid panel is recommended for monitoring — usually through primary care. Also relevant after anthracycline exposure and early menopause.			
Ferritin + iron studies	Persistent fatigue. Common post-treatment deficiency.			
TSH (+ free T3/T4 if indicated)	Fatigue and weight change. Thyroid dysfunction is common after cancer treatment.			
Vitamin D (25-OH)	Bone health after early menopause, and reduced outdoor activity during treatment.			

TEST	WHY I AM ASKING	YES	NO	NOTE
Vitamin B12 + folate	Fatigue, and reduced intake during treatment.			
Calcium (+ phosphate)	Bone health — relevant with early or treatment-induced menopause.			
LDH	General marker, part of routine survivorship bloods.			
Urinalysis	Simple baseline.			

GROUP 2 · ASK ONLY IF YOU THINK THEY ARE INDICATED

I understand these are not routine and several carry specific eligibility criteria. I have noted the symptom or reason I am asking. Please skip any that do not apply to me.

TEST	WHY I AM ASKING	YES	NO	NOTE
Fasting insulin	Metabolic health and weight change. I understand this may not be funded.			
Homocysteine	Cardiovascular and B-vitamin status.			
Uric acid	General metabolic picture.			
AM cortisol	Ongoing fatigue and disrupted sleep.			
Oestradiol + FSH	Menopausal status on endocrine therapy.			
DHEA-S	Fatigue and adrenal picture.			
Thyroid antibodies	Only if TSH is abnormal.			
Zinc + copper	Post-treatment nutritional status, taste changes, slow healing.			
Immunoglobulins	Recurrent infections since treatment.			

GROUP 3 · CURIOSITY — GUIDED BY YOUR VIEW

These are the ones I am most curious about. I know routine marker surveillance is not recommended in asymptomatic patients, and I am not asking you to work against guidelines — my interest is in a baseline picture of my own biology and whether it shifts across 90 days of daily exercise. I would genuinely value your view on whether any of them would tell me something useful. If not, I am happy to arrange them privately.

TEST	WHY I AM ASKING	YES	NO	NOTE
CA-125	Already run annually as part of my BRCA1 ovarian surveillance — noted here only so the full picture is on one page. No change requested.			
CA 15-3 + CEA	These are the breast-relevant pair and are usually run together, as CEA picks up some cases where CA 15-3 stays normal. As a BRCA1 carrier with a personal breast cancer history I would like to know whether you think a baseline is worth having. I understand routine marker surveillance is not recommended in asymptomatic patients, and that a mildly raised result is more often benign than not.			
EBV antibody panel	Most adults carry EBV dormant, and reactivation is more likely when immune surveillance has been suppressed. I would like to know where I sit, and whether it moves over 90 days.			

TEST	WHY I AM ASKING	YES	NO	NOTE
NK cell count	This is the immune population my whole programme is aimed at supporting, so it is the number I would most love to watch. Very happy to fund this one myself if it is not something you can order.			

One question I would really value your answer to: of the tests you have not ordered, are there any you would consider if a particular symptom were present, or at a later point in my follow-up? Anything you can tell me here saves us both an appointment later.

This is a patient-prepared discussion document, not a clinical recommendation and not medical advice. The decision about which tests are clinically appropriate rests entirely with the treating clinician.

Allied Health

Asking about a chronic disease management plan — for the GP, not the oncologist

I would like to ask whether I am eligible for a GP management plan with team care arrangements, so that some allied health visits are subsidised. My understanding is that this gives a limited number of subsidised sessions per calendar year, shared across whichever providers are included — not per provider. If I qualify, I would like the plan to cover the three below, because my post-treatment needs cut across all of them.

THE THREE I WOULD LIKE INCLUDED

PROVIDER	WHY	YES	NO	NOTE
Pelvic floor physiotherapist	I am undertaking a skipping-based exercise programme, and stress incontinence is a known issue with impact exercise — more so after childbirth, and more so again with the drop in oestrogen from treatment-induced menopause. I understand I can self-refer, so this is about cost rather than access. I would like my technique assessed properly rather than guessing from written instructions.			
Lymphoedema physiotherapist	I have had lymph nodes removed and I am monitoring limb circumference weekly. I would like a relationship established now, so that if the difference between my surgery side and reference side changes I already have someone to call rather than starting from scratch. Early intervention is the whole point.			
Accredited exercise physiologist	AEPs are specifically trained in exercise prescription for cancer survivors. I would value one reviewing my programme — particularly the load on my surgery side, and progression given any bone density considerations.			

Two questions I would value your answer to: do I qualify for a plan at all, and if the subsidised visits are shared across providers rather than given per provider, which of the three would you prioritise for someone in my position? I would rather use them well than spread them thin.

Plan prepared? Yes / No / Not eligible	Providers included	Visits available per calendar year
_____	_____	_____

Eligibility and the number of subsidised visits are set by Medicare and change over time — please confirm what currently applies. Pelvic floor physiotherapy can also be accessed by self-referral without a plan; this request is about affordability rather than access. Patient-prepared request, not a clinical recommendation.

I have looked up practitioners who hold the specific accreditation for each of these — names and contact details are on the following page, so the referral can be addressed directly rather than left open.

Finding the Practitioner

The specific accreditations, and the national registers that list them

"Lymphoedema physiotherapist" and "pelvic floor physiotherapist" are descriptions anyone may use. The accreditations below are not — they are awarded by the relevant national bodies and each has a public register. I have noted the practitioners I have found so the referral can be addressed to a named person.

AREA	WHAT TO ASK FOR	WHERE TO LOOK
Pelvic floor	APA Titled Women's, Men's and Pelvic Health Physiotherapist	Continence Health Australia service directory — continence.org.au CHA physiotherapy directory — cfaphysios.com.au Australian Physiotherapy Association — choose.physio National Continence Helpline — 1800 33 00 66
Lymphoedema	ALA Accredited Lymphoedema Practitioner	National Lymphoedema Practitioners Register — lymphoedema.org.au The only recognised register in Australia and New Zealand, administered by the Australasian Lymphology Association. Search from 20 km, widening to 100 km outside metropolitan areas.
Exercise physiology	Accredited Exercise Physiologist (AEP), ESSA	Exercise & Sports Science Australia — essa.org.au Look for cancer-specific experience as well as accreditation.

PRACTITIONERS I HAVE FOUND

For the referring doctor to address the referral to. Accreditation confirmed with the practice by phone.

Pelvic health physiotherapist

Name | Practice | Phone

Lymphoedema practitioner

Name | Practice | Phone

Accredited exercise physiologist

Name | Practice | Phone

Pelvic floor physiotherapy can be accessed by self-referral in Australia — including this here is about the management plan and cost, not access. Registers and accreditation requirements change; please confirm anything that matters clinically. Patient-prepared request, not a clinical recommendation.

Bone Density Scan

Request for referral — separate from my pathology request

This is a different kind of request to the blood tests, so I have put it on its own page. A DEXA scan is imaging, referred to a specialist or consultant physician, and the Medicare item depends on which clinical indication applies — so it cannot go on a pathology form.

Patient	Date	Requesting from
_____	_____	_____

WHY I AM ASKING

I am undertaking a structured daily exercise programme that is deliberately weight-bearing — bodyweight squats and the landing phase of skipping both load bone directly. Bone density is one of the few things this programme is designed to affect that I cannot measure from a blood sample.

I would like a baseline now so any change over the next one to two years is measurable rather than assumed. I understand a repeat is generally not appropriate before 12 to 24 months and I am not asking for frequent monitoring. I also understand that if I do not meet an MBS criterion no rebate applies and I would be charged a private fee — I am willing to pay privately, I would just like to know which applies before booking.

INDICATIONS THAT MAY APPLY TO ME · PLEASE TICK ANY THAT DO

The MBS bone densitometry items require the referral to state the clinical indication. These are the ones I believe could be relevant — you would know better than I do which, if any, apply.

TICK	INDICATION	NOTE
	Aromatase inhibitor therapy Current or being considered. Bone loss on AI therapy is a recognised indication and was the subject of a specific MSAC application.	
	Premature or treatment-induced menopause Chemotherapy-induced ovarian failure, or menopause before the usual age.	
	Risk-reducing oophorectomy Surgical menopause following BRCA risk-reducing surgery.	
	Prolonged corticosteroid therapy Including steroid courses given during chemotherapy.	
	Previous minimal-trauma fracture A fracture from a fall at standing height or less.	
	Other condition associated with bone loss Thyroid, coeliac, inflammatory or other.	
	None of the above apply In which case I am happy to proceed as a private patient.	

FOR THE REFERRING DOCTOR

MBS item applied 12306 · 12312 · 12315 · 12320 · 12321 · 12322	Referred to	Rebate applies? Yes / No / Private fee
_____	_____	_____

Bone densitometry is referred to a specialist or consultant physician, and the interpretation and report must be provided by one. MBS item numbers and eligibility criteria change — please confirm current requirements. This is a patient-prepared request, not a clinical recommendation and not medical advice.