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| **GP Direct Neuro-Oncology MDT Proforma****IT IS THE GP’s RESPONSIBILITY TO INFORM THE PATIENT THAT THE SCAN IS ABNORMAL AND REQUIRES FURTHER SPECIALIST ASSESSMENT****THE MDT WILL CONTACT THE PATIENT FOLLOWING RECEIPT OF THIS FORM** |
| **Date of meeting:** |       |
| [ ]  New MDT referral | [ ]  Previously discussed | **Please send Completed Neuro-Onc MDT Referral forms to:-** **RK9CancerServices@nhs.net** |
| **Please indicate, this section must be completed to ensure the patient is discussed in the correct sub-group.** | [ ]  Brain/CNS tumour[ ]  Skull base tumour[ ]  Pituitary[ ]  Spinal tumour |  |
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| **NHS Number:** | <NHS number> |
| **Surname:** | <Patient Name> | **Forename:** | <Patient Name> |
| **DOB:** | <Date of Birth> | **Age:** | <Patient Age> |
| **Patient Telephone:** | <Patient Contact Details> |
| **Patient Address:** | <Patient Address> |

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| **Usual/Registered GP** | <GP Name> | **GP Practice Telephone** | <Organisation Details> |
| **GP Practice Address** | <Organisation Address> |
| **Generic Practice email address** | <Organisation Details>**Provision of a practice email address will ensure timely, reliable feedback of MDT outcome to the GP** |

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| **Send this referral form to** **RK9cancerservices@nhs.net****. Initial report will be sent direct to the GP by neurosurgery MDT. Subsequent enquiries for patients outside UHP catchment to be made via the local trust:** |
| **RCHT** | **rch-tr.ref12cancerservices@nhs.net** | **SD&T** | **cancerservices.sdht@nhs.net** |
| **RD&E**  | **rh8.cancerservices@nhs.net** | **NDDH** | **a.minns@nhs.net**  |

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| **Date of decision to refer:** | <Today's date> | **2WW or Non 2WW:** |       |
| **Date of receipt of referral:** |       | **CWT 62 target date:** |       |
| **Date of 1st appointment:** |       |

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| **Date of onset of symptoms:** |       |
| **Headline Reason for Referral** |       |
| **Clinical summary:****To include symptom history including functional deficit, and relevant exam findings including neurological and cognitive deficit.** |        |
| **Social History:** To include cohabitants, occupation, nearby social support.  |       |

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| **Past medical history/co-morbidites:** | <Problems> |
| **Medication:** | <Repeat Templates> |

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| **Performance Status** |
| It would be helpful if you could provide performance status information (please tick as appropriate)[ ]  Fully active [ ]  Able to carry out light work [ ]  Up & about 50% of waking time [ ]  Limited to self-care, confined to bed/chair 50%[ ]  No self-care, confined to bed/chair 100% |

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| **Investigations and Imaging** |
| **LOCAL ACUTE TRUST** |       |
| **Radiological findings** |       |
| **MRI head** |       |
| **CT head** |       |
| **CT TAP** |       |
| **Other** |       |

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| **Pathology – MDT USE ONLY** |
| **Diagnostic biopsy or Surgical treatment** |       |
| **Date of biopsy:** |       |
| **Biopsy Histology:** |       |