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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**](mailto: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 |  | |
|  | | | |
| **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**](mailto: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**](mailto:rch-tr.ref12cancerservices@nhs.net) | **SD&T** | [**cancerservices.sdht@nhs.net**](mailto:cancerservices.sdht@nhs.net) |
| **RD&E** | [**rh8.cancerservices@nhs.net**](mailto: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:** |  |