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| --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | **KCH Patient Number** |     **King’s College Hospital Neuro - MSCC MDT Proforma :**  **Date and Time of Referral:**  **PLEASE COMPLETE THE FORM and email to** [**kch-tr.neuro-mscc@nhs.net**](mailto:kch-tr.neuro-mscc@nhs.net)  **For more information contact MSCC Nurse on 020 3299 5468 09:17:00 Monday to Friday excluding bank holidays**  **Out of hours 02032994207** Link to referral portal <https://nww.ihtl.nhs.uk/neurosurgery/>  Link to MSCC referral guide- <https://www.kch.nhs.uk/service/a-z/metastatic-spinal-cord-compression>  **ALL FIELDS ARE MANDATORY** | | | | | |
| **Patient’s Details** | | | **Referring Hospital Details** | | |
| **Name:** | | | Choose Hospital | | |
| **DOB:** Click here to enter a date. | | | Ward Contact number | | |
| **NHS No:** | | | Referrers Name: | | |
| **Address:**  **Telephone number:** | | | **Designation** | | Choose option |
| **GP Name:**  **Address:**  **Telephone number:**  NHS email address : | | | Referrer Contact  **Telephone number :**  NHS email address : | | |
| **Oncology Consultant :**  **Telephone number:**  NHS email address: | | |
| **Next of Kin Contact details** | | | **Where is the patient currently?** Choose option  **OTHER:** | | |
| Date of admission Click here to enter a date. | | |
| **Key Worker/ CNS:** | | |
| Brief and relevant clinical details | | | | | |
| Exact date of first onset of symptoms: Click here to enter a date.  Brief history of Presentation: | | | | | |
| **Previous history of cancer** Choose option  Type of cancer:  If this is a new suspected cancer, have you contacted the acute oncology service?  Choose option  Type of cancer (confirmed histology):  Does the oncology consultant want patient to have surgery? Choose option  What is the estimated Prognosis: Choose option | | | | **Oncological treatment History**  Previous radiotherapy to the spine?  **Choose option**  If yes please specify date:  Click here to enter a date.  Areas and dose | |
| Past Medical History: | | | | | |
| Imaging – please link to Kings PACS system | | | | | |
| MRI Whole Spine **Choose option** Date and report Click here to enter a date. | | | | | |
| CT CAP insert date and report Click here to enter a date. | | | | | |
| CT cervical spine **Choose option** ( to be completed for all patients with metastasis in cervical spine) | | | | | |
| Other scan results (PET CT, Bone scan , other)  Tumour markers ( including Myeloma, PSA, ): | | | | | |
| Motor and Sensory status | | | | | |
| **Motor Score**  **Full power in upper extremities** Choose option Full Power in Lower extremities Choose option  If any muscle weakness pleases fill the table   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Upper limb Right** | **Choose option** | **Upper limb left** | **Choose option** | **Lower limb Right** | **Choose option** | **Lower limb Left** | **Choose option** | | Shoulder abduction | **Choose option** | Shoulder abduction | **Choose option** | Hip flexion | **Choose option** | Hip flexion | **Choose option** | | Elbow flexion | **Choose option** | Elbow flexion | **Choose option** | Hip extension | **Choose option** | Hip extension | **Choose option** | | **Elbow extension** | **Choose option** | **Elbow extension** | **Choose option** | Knee Flexion | **Choose option** | Knee Flexion | **Choose option** | | Wrist flexion | **Choose option** | Wrist flexion | **Choose option** | Knee extension | **Choose option** | Knee extension | **Choose option** | | Wrist extension | **Choose option** | Wrist extension | **Choose option** | Ankle dorsiflexion | **Choose option** | Ankle dorsiflexion | **Choose option** | | Finger abduction | **Choose option** | Finger abduction | **Choose option** | Planter Flexion | **Choose option** | Planter Flexion | **Choose option** | | | | | | |
| Urinary symptoms: Choose option  Date catheter inserted Click here to enter a date.  Bowel dysfunction **Choose option**  Date of onset Click here to enter a date.  Gait disturbance **Choose option**  Pins & Needles/Numbness/Sensory loss **Choose option** | | Does patient have severe pain in the Spine: **Choose** **option**  Specific Location: Choose option  Does back pain improve when patient lays flat? **Choose** **option**  Does back pain worsen when patient is verticalized (i.e sits or stands): **Choose** **option**  Does back pain worsen on movement? **Choose** **option**  VAS pain scale: **Choose option** | | | |
| Current WHO Performance Status **Choose** **option** | | **ASIA Impairment Scale Choose option** | | | |
| WHO Performance Status prior to presentation  **Choose** **option** | | **Mobility**  Current status **Choose option** -  Date last mobilised independently Click here to enter a date. | | | |
| Frailty scale **Choose** **option** | |
| Steroid Administration ( Give16mg bolus of dexamethasone followed by 8mg BD with PPI cover | | | | | |
| Anticoagulant/Antiplatelet use **Choose option**  Drug and dose:  Date of last dose anticoagulant/Antiplatet drug Click here to enter a date. | | | | | |
| Thromboprophylaxis: **Choose option** | | | | | |
| Did they have MSCC Alert card / information **Choose option** | | | | | |
| MRSA Status **Choose option** Covid Status **Choose option** | | | | | |
| Patient’s status | | | | | |
| Has patient been informed of cancer /suspected cancer diagnosis **Choose option** | | | | | |
| Do they want to consider surgery **Choose option** | | | | | |
| Question for MSCC MDM: | | | | | |
| IT is the responsibility of the referrer to ensure that all imaging studies are made available on the PACS via IEP | | | | | |
| Outcome : Centre use only | | | | | |
| *Acute neurosurgical decision Date & Time* | | | | | |
| Management decision | **Choose option** | | | | |
| Stability:  **Choose option**  **SINS score: Choose option**  **Epidural spinal cord compression  (ESCC) grading scale Choose option** | | **Vertebral body Collapse**    **Choose option**  **Location**  **Brace advise**  **Choose option** | | | |
| *Neurosurgery Clinic Review* | | | | | |
| *Other Comment* | | | | | |
| Date and time of definitive treatment decision | | | | | |
| Date and time of start of definitive treatment | | | | | |
| Completed by: **Click here to enter a date.** (*name in capitals) (signature)* | | | | | |