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| **REFERRAL FOR NEUROENDOCRINE MDM DISCUSSION**  Completed forms need to be emailed to [kch-tr.hpbreferrals@nhs.net](mailto:kch-tr.hpbreferrals@nhs.net) | | |
| **Patient Details** | | |
| Patient’s surname: \* | Date of Birth: \* | Sex: \* |
| Patient’s forename: \* | NHS number: \* | |
| Home address: \*  Postcode: | Home telephone number: | |
| Mobile telephone number: \* | |
| Patient's GP address: \* | GP telephone number: | |
| **Is patient aware of their diagnosis?** \* | | |
| **Is patient aware of referral to King’s?** \* | | |
| **Will patient require an interpreter? If so, which language?** \* | | |
| **Will patient require transport?** \* | | |
| **Referring Organisation** | | |
| Referring clinician and specialty: \* | | |
| Referring organisation name: \* | | |
| Referring organisation hospital number: \* | | |
| Name of person completing proforma: \* | Contact phone: | |
| Contact e-mail: | |
| Local CNS contact details: \* | Contact phone: \* | |
| Contact e-mail: \* | |
| **Reason for Referral** \* | | |
| Information only (does not require MDM discussion) |  | |
| Diagnostic tests only (please specify) |  | |
| MDM opinion only (specify question to be answered) |  | |
| For MDM discussion and possible treatment |  | |
| Date of referral to MDM |  | |
| **Pathway Details** | | |
| 2WW pathway clock start date (if applicable) |  | |
| 62 day breach date |  | |
| Date first seen |  | |
| Patient Pathway Identifier Number\* |  | |
| Adjustments applied to pathway (if applicable) |  | |
| HNA completed (Y/N) | Date completed (please attach if available): | |
| **Minimum Clinical Information for MDM discussion** \* | | |
| Presenting symptoms |  | |
| Relevant medical/surgical history including comorbidities   * Diabetes * Heart disease * On an anticoagulant |  | |
| Performance status (0-4) |  | |
| History of previous cancer (Y/N): |  | |
| Date of diagnosis (if applicable): |  | |
| Type of cancer and staging (if applicable): |  | |
| Treatment details. Please include all surgery dates and full chemotherapy/radiotherapy regimes and duration, including date of last therapy (if applicable): |  | |
| Histology or cytology results (if applicable): |  | |
| Treating hospital and name of Consultant (if applicable): |  | |
| **Investigations (specify dates performed and attach reports if available)** | | |
| CT |  | |
| MRI |  | |
| Nuclear Medicine investigations (PET scan, Octreotide scan, MiBG scan) |  | |
| Endoscopic procedures (OGD, EUS, Colonoscopy, ERCP) |  | |
| Diagnosis( ICD10 code) |  | |
| Full blood count |  | |
| Liver function tests \* |  | |
| Full renal function including eGFR |  | |
| Tumour markers\* |  | |
| Local MDM outcome |  | |