|  |
| --- |
| **REFERRAL FOR NEUROENDOCRINE MDM DISCUSSION**Completed forms need to be emailed to 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 |   |