Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

LUNG MDT Referral Proforma

Patient Name:	QEHB/NHS Number:	D.O.B:
Patient Address:	Patient Tel No:	GP:
Referring Hospital:	Referring Consultant:	CNS:
Referrer Email:	Referrer phone number:	
Referral to QEHB Consultant: ◯ Yes ◯ No	Name:	
CWT TARGET DATE:	◯ 2WW ◯ UPGRADE	

Clinical Details: (Include prior treatment, radiology, histology and PMH, current medication):

Performance Status: BMI:

Significant Comorbidities:

Question for MDT:

Is referral for treatment: ◯ or MDT discussion only: ◯

DIAGNOSIS:	DATE:	
HISTOLOGY:	Location:	Date:
CHEST X-RAY:	Location:	Date:
CT SCAN:	Location:	Date:
PET-CT:	Location:	Date:
SPIROMETRY:	Location:	Date:
TLCO (Transfer Factor):	Location:	Date:

Ensure all histology slides/reports and imaging films/reports are sent with the referral.

Other:

Date Patient agreed to referral to QEHB:

Send completed referral form to QEHLungMDTRequest2@uhb.nhs.uk

Please note cut off time for inclusion in MDT is Thursday 12:00hrs

Incomplete forms will result in delays to the patient pathway. Referral will be accepted when all essential information is received.

Email form Save form