Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

Neuro-Oncology 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: ◯ No ◯ Yes	Name:	CWT TARGET:
◯ 2WW ◯ UPGRADE	Patient Location:	

PLEASE EMAIL MDT CO-ORDINATOR WITH PATIENT LOCATION IF PATIENT IS BEING MOVED

Clinical Details (Include prior treatment/Cancer treatment and Oncologist, radiology, histology, PMH and medication):

Dose of steroids and date started:

WHO Performance Status: GCS: BMI:

Significant Comorbidities:

Question for MDT:

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

DIAGNOSIS:	DATE:	
HISTOLOGY:	LOCATION:	DATE:
CT SCAN (Chest/abdo/pelvis):	LOCATION:	DATE:
CT SCAN BRAIN	LOCATION:	DATE:
MRI :	LOCATION:	DATE:

(MRI Brain +- contrast unless contra-indicated as a minimum for discussion)

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

Other:

Date Patient agreed to transfer to QEHB:

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

Please note cut off time for inclusion in MDT is Monday 1200hrs

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

Email form Save form