Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

# Oesophago-gastric 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:

Question for MDT:

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

| | | |
|---|---|---|
| DIAGNOSIS: | DATE: | |
| HISTOLOGY: | Location: | Date: |
| CT SCAN: | Location: | Date: |
| PET-CT: | Location: | Date: |
| EUS: | 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 UpperGIMDT@uhb.nhs.uk**

**Please note cut off time for inclusion in MDT is Tuesday 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