Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

SKULL BASE 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: ◯ 2WW ◯ UPGRADE

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

Performance Status: BMI:

Significant Comorbidities:

Question for MDT:

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

DIAGNOSIS:	DATE:	
HISTOLOGY:	LOCATION:	DATE:
CT SCAN:	LOCATION:	DATE:
MRI:	LOCATION:	DATE:
VISUAL FIELD TESTS:	LOCATION:	DATE:

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 SkullBaseMDT@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