

Department of Neurosurgery

Every Acute Referral must be discussed with the On-call Neurosurgical Registrar

Referral FORM to the Brain/CNS MDT @ HRI

REFERRER DETAILS			
Name of referrer, ward and hospital			
Consultant & Speciality			
Date of referral			
Referrer's contact details (required to provide feedback)	Phone No		
	Fax No		
	Email		
Neurosurgeon referred to & Neurosurgical Registrar on call			
CLINICAL DETAILS			
Patient Name (forename, surname)			
Date of birth and age		Male/ Female:	
NHS Number/HEY Number (obligatory)			
Location of patient			
Primary/Secondary or Unknown			
If secondary tumour then: Name of oncologist dealing with primary - Dr			
Prognosis for primary (include median survival)	Status of staging work up	Is the primary controlled?	
Imaging on (tick as appropriate)	HEY PACS		Centricity
	NLAG PACS		CD
Date of imaging			
History of Presenting Illness:-			
Past History/ Medications:-			
Right/Left handed :- Neurological Status :-			
Patient's wishes/concerns/views (if known) :-			
WHO Performance status (tick appropriate box)			
0	Normal activity		
1	Symptoms demonstrated, but patient remains ambulatory, and able to perform self-care		
2	Ambulatory >50% of the time and requires occasional assistance		
3	Ambulatory <50% of the time and requires nursing care		
4	Bedridden		

Please send to:

Jo Ward, Brain/CNS MDT Administrator, 6th Floor Staff Residences,
Hull Royal Infirmary, Anlaby Road, Hull, East Yorkshire, HU3 2JZ.
Tel: 01482 607841. Fax: 01482 607892.
Email: Jo.Ward@hey.nhs.uk , HullNeuroOncology@nhs.net

The form and imaging MUST be received by midday Thursday for the case to be discussed in same week Friday MDT.