Referral form to the Brain/CNS Cancer Network MDT @ HRI

REFERRER DETAILS		
Name of referrer, ward and hospital		
Consultant & Specialty		
Date of referral		
Referrer's contact details (required to provide feedback)	**Phone No**	
	Fax No	
	Email	

CLINICAL DETAILS			
Patient Name (forename, surname)			
Date of birth and age			**Male/ Female:**
NHS Number/HEY Number (obligatory)			
Location of patient			
Date of last imaging:			
Discussed at NSMDT:		**Date:**	
Treatment to date:			
Current management plan:			

History of Presenting Illness:-

Past History/ Medications:-

Right/Left handed :-
Neurological Status :-

Reasons for discussion at Cancer Network MDT:-
Physical
Psychological
Social
Spiritual

Patient's wishes/concerns/views (if known) :-

Carer's identity and needs:-

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 HRI
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.