

# SARCOMA MDT REFERRAL

Please note that if the full and correct information isn’t given below this may delay your patient’s discussion at the MDT.

Please complete this form electronically in full and send it in Word format (i.e. not as a scanned PDF) to [mdtsarcoma@ouh.nhs.uk](mailto:mdtsarcoma@ouh.nhs.uk)

Please also attach any scan reports/pathology reports/clinical letters

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of decision to refer** |  | | | | | | **Date of referral** | |  | | | |
| **Referral Status** | Please tick one of the below:  O 2WW NHS  O Routine NHS  O PRIVATE PATIENT | | | | | | **If 2WW point on pathway at date of referral** | |  | | | |
| **PPI:** |  | | | | | | **OUH MRN:** | |  | | | |
| **Referring doctor/ institution and contact details for MDT outcome** | **Name and address:** | | | | | | | | | | | |
| **Phone No:** | | | | | | | | | | | |
| **Email address** | | | | | | | | | | | |
| **Patient name** |  | | | | | | **Patient DOB** | |  | | | |
| **Patient phone no.** |  | | | | | | **Patient address** | |  | | | |
| **Patient NHS number** |  | | | | | |
| **Is patient aware of the referral/ diagnosis** | **Y/N** | | | | | |
|  | Please tick one of the below:  O For MDT opinion only  O For Radiology/Pathology opinion only  O Other: Give Details: | | | | | | | | | | | |
| **Specific question for the MDT?**  **Without this there can be no discussion** |  | | | | | | | | | | | |
| **Patient presents with:** |  | | | | | | | | | | | |
| **Diagnosis:** |  | | | | | | | | | | | |
| **Staging** | **T** | | | | | **N** | | | | | **M** | |
|  | | | | |  | | | | |  | |
| **Pathology review** | **Y/N** | | | **Where are the pathology specimens?** | | | | |  | | | |
| **Biopsy or post-surgery?** |  | | | **Date of biopsy/ surgery.** | | | | |  | | | |
| **If pathology is to be discussed please ensure that all blocks and slides are sent urgently to:** | | | | **Professor Athanasou/Dr Orosz**  **Histopathology Dept,**  **Nuffield Orthopaedic Centre**  **Windmill Road, Oxford OX3 7HE** | | | | | | | | |
| **Radiology review** | | | **Y/N** | **Please detail what scans have been performed: where and when?** | | | | |  | | | |
| **Treatment undertaken so far:** | | | | | | | | | | | | |
| **Performance Status:** | | 0 | | | 1 | | 2 | | | 3 | | 4 |
| **Co-morbidities:** | |  | | | | | | | | | | |
| **Does the patient:** | | **Have any implants that may affect the patient having an MRI?**  **Y/N** | | | | | | **Take anti-coagulation medication?**  **Y/N** | | | | |

***Please note that referral for discussion in the MDT does not constitute a transfer of care and transfer of care will only be accepted following discussion at the MDT and upon receipt of a completed intra-trust transfer of care form.***

***Please do not give out the sarcoma contact numbers to patients.***