

# Oxford Skull Base Tumour MDT Referral Form

Please complete all the fields below. If you have any letters/scan reports etc. that you think will be useful please attach them, but this form MUST be completed digitally.

If we don’t have **sufficient information** your patient will NOT be discussed.

Referral form needs to be completed **digitally**.

Up to date scans (head MRI and/or CT) **no older than 3 months**.

Specify **department / private clinic** where scans were performed.

Specify **question for the MDT**. Without a specific question there can be no discussion.

*Performance status* **cannot** be left blank.

MDT is 1st and 3rd Wednesday of the month.

Deadline **Friday at 12:00 noon.**

Outcomes will be sent back to referrer who needs to inform the patient they referred [oxfordskullbase.tumourmdt@ouh.nhs.uk](mailto:oxfordskullbase.tumourmdt@ouh.nhs.uk)

## Patient details

|  |  |
| --- | --- |
| Surname: |  |
| Forename: |  |
| Date of Birth: |  |
| NHS Number: |  |
| Address: |  |
| Postcode: |  |
| Telephone: |  |
| Next of Kin: |  |
| Sex: | M F |
| Patient Current Location:  Hospital: Ward:  Home: |  |

## Hospital details

|  |  |
| --- | --- |
| Referring Hospital: |  |
| Your Name: |  |
| Your Designation: |  |
| Your email: |  |
| Referring Consultant: |  |
| Consultant Email: |  |
|  |  |
| Date referral completed: |  |

## QUESTION FOR MDT?

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| --- |
|  |

## Is patient aware of MDT referral?

Or if patient lacks capacity is next of kin aware? Please give details.

|  |
| --- |
|  |

## Clinical history

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| --- |
| **Clinical History \*(MUST** include presenting symptoms, clinical history and co-morbidities, any previous treatments) |

| **Investigation** | **Department and date** | **Findings** |
| --- | --- | --- |
| MRI Head |  |  |
| CT Head |  |  |
| CT CAP |  |  |
| Audiology |  |  |
| Vision |  |  |
| Facial Palsy |  | House Brackman Score: **I** normal: **II** slight: **III** moderate: **IV** moderately severe: **V** severe: **VI** no function |
| Cranial nerves deficit |  |  |

## Performance history and medication

### Current performance status (MANDATORY)

|  |  |
| --- | --- |
| **0**  fully active, able to carry on all pre-disease performance without restriction |  |
| 1 = Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work |  |
| 2 = Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours |  |
| 3 = Capable of only limited self-care, confined to bed or chair more than 50% of waking hours |  |
| 4 = Completely disabled. Cannot carry out any self-care. Totally confined to bed or chair |  |

## Medication

| **Steroids Administration-** | **Anticoagulant:** |
| --- | --- |
| Date commenced:  Dose:  Response: | Dose:  Date last dose: |

**Please all referral to be sent via email to the Skull Base MDT Coordinator**

[oxfordskullbase.tumourmdt@ouh.nhs.uk](mailto:oxfordskullbase.tumourmdt@ouh.nhs.uk)