Gynaecology MDM Referral Form

DEADLINE: Friday 12:00pm

Referred from Independent Sector or NHS:
Which Hospital if referred from IS:

Patient Name:
Patient HCN:
Patient DOB:
Patient Aware of findings: YES ☐ NO ☐
Information given: YES ☐ NO ☐
CNS informed ?: YES ☐ NO ☐

Referring Trust:
Referring Clinician:
Other Referring Clinician:
Clinician Email:
Contact Number:
Presenting Clinician:

Reason for discussion:
Review: MRI ☐ Path ☐ Management ☐ USS ☐ PET ☐ CT ☐
Other (Please specify):
Location of Scan & Pathology:
Reason for Review of Scan / Pathology:

Co Morbidities: COPD ☐ Diabetes ☐ IHD ☐ CHF ☐Renal Disease ☐ CVD ☐ PVD ☐ Hypertension ☐
Dementia ☐ Malignancy Other (Please specify):
Blood Thinning Medication No ☐ Yes ☐ Please list detail

Exercise Tolerance: **Performance Status:**
Patient likely fit for Surgery ? : YES ☐ NO ☐

Question for MDM:

Reason for discussion:

Clinical Summary:

Suspected Primary Site:

Endometrial ☐	Uterus (not endometrial) ☐	Cervix ☐	Vulva/Vagina ☐	Ovarian ☐	Complex / Other ☐

Tumour markers CA125 ☐ CEA ☐ CA19-9 ☐ Date:
Family Complete Yes ☐ No ☐ BMI

Submit form