

OG MDM REFERRAL FORM

DEADLINE: Wednesday 15:00pm

Referrals to the OG MDM must fulfil the following criteria:

1. Your local MDT coordinator must be notified of the referral to enable them to transfer the patient on CaPPS for discussion.
2. Referral form is mandatory for all new Regional MDM discussions
3. Referrals to MDT must be made by a Consultant.
4. A local MDT discussion should have taken place prior to referral.
5. A clear question for the MDT to discuss must be stated on the referral form **and** all investigations that need discussed must be available

Patient Name

DOB

HCN

Date of Referral

Local CNS informed YES NO

Referring Clinician

Other clinician please specify

Referring Trust

Patient Aware of Diagnosis YES NO

Copy of MDM Report to

Diagnosis:

Histology:

Location Oesophageal Junctional Gastric

Other (please specify)

Clinical Summary:

Question to MDM:

Reason for Discussion:

Dysphagia Score

Weight

% weight loss over last three months

Feeding route

Comorbidities:

COPD Diabetes Dementia IHD CHF Renal Disease Hypertension CVD PVD

Other Malignancy

Other Condition

Other comorbidity please specify

Blood thinning medication YES Please specify

NO

Performance Status

For discussion:

OGD/Path Date

Findings

CT Date

Requested - Await date prior to MDM discussion

PET Date

Requested - Await date prior to MDM discussion