Regional Thyroid MDM Referral Form

DEADLINE: Thursday 12:00pm prior to MDM

Patient Name:
DOB:
HCN:
Patient Aware of referral/Diagnosis
Yes ☐ No ☐
Please indicate if for registration purposes
Yes ☐ No ☐

MDM Consultant:
Other Consultant
Referring Trust:
MDM Update to:

Suspect ☐
Confirmed ☐
Diagnosis
Other ☐

Investigations performed/requested
MRI ☐ Date:
CT ☐ Date:
PET ☐ Date:
USS ☐ Date:
Other ☐ Date:

Clinical Summary

Question to MDM:

Reason for discussion:

Co-morbidities

COPD ☐ Diabetes ☐ IHD ☐ CHF ☐ Renal Disease ☐ CVD ☐ PVD ☐ Ascites ☐ Encephalopathy ☐
Hypertension ☐ Dementia ☐ Other Malignancy

Blood Thinning Medication Yes ☐ Please detail:
No ☐

Performance Status

Expected to be fit for treatment: Yes ☐ No ☐

Smoking Status **Alcohol Status**

Weight **Percentage weight loss over last three months**

Dysphagia Score:

Discuss: Pathology: Cytology ☐ Histology ☐ CT ☐ MRI ☐ PET ☐ Further Management ☐

Submit form