Belfast Health and Social Care Trust
caring supporting improving together

REGIONAL UROLOGY MDM REFERRAL FORM

Patient Name:		**Referring Trust:**	
Patient DOB:		**Referring Clinician:**	
Patient HCN:		**Referrer Email:**	
Patient Aware: YES ☐ NO ☐		**Presenting Clinician:**	
Information given: YES ☐ NO ☐		**CNS informed** YES ■ NO ☐	

Clinical Summary:

Question to MDM:

Clinical details

Tumour Group: Prostate ☐ Bladder ☐ Renal ☐ Testicular ☐ Penile ☐ Other ☐

Performance Status		**ASA Grade**	
Exercise Tolerance		**eGFR**	
T Stage		**N Status**	**M Status**

Blood thinning medication YES ☐ NO ☐

Suitable for Clinical Trials YES ☐ NO ☐
Standard of Care Pathway YES ☐ NO ☐

Imaging performed to date : MRI ☐ USS ☐ PET ☐ CT ☐ Bone scan ☐
Other ☐ **If other please specify**

For discussion of : MRI ☐ USS ☐ PET ☐ CT ☐ Bone scan ☐ Pathology ☐ Management ☐
Other ☐ **If other please specify**

Submit