

# ENDOCRINE MDM REFERRAL FORM

**DEADLINE: FRIDAY 17:00PM PRECEDING MEETING**

<b>Patient Name:</b>	<b>MDM Consultant:</b>
<b>Address:</b>	<b>Referring Consultant:</b>
<b>DOB:</b>	<b>Copy of MDM report to:</b>
<b>HCN:</b>	
<b>BCH No.</b>	<b>Please indicate if for registration purposes:</b>
<b>Contact No.</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>RED FLAG referral from GP?</b> <input type="checkbox"/>	<b>Malignant:</b> <input type="checkbox"/> <b>Benign:</b> <input type="checkbox"/> <b>Suspicious:</b> <input type="checkbox"/>
<b>Patient upgraded to suspect cancer?</b> <input type="checkbox"/>	<b>Thyroid</b> <input type="checkbox"/> <b>Parathyroid:</b> <input type="checkbox"/> <b>Adrenal:</b> <input type="checkbox"/>
<b>Is this an incidental finding?</b> <input type="checkbox"/>	<b>Other (please specify)</b> <input type="checkbox"/>
<b>Date Referral received</b>	

**Clinical Summary:**

**Performance Status**

**Question to MDM:**

**Reason for discussion:**

**Investigations**

Type:

Date:

**Radiology Investigations**

MRI	CT	OTHER
Date:	Date:	Date:

**Histology**

Date:	Date:	Date:
Result:	Result:	Result: