Regional Head & Neck MDM Referral Form

DEADLINE: Thursday 15:00pm

Patient Name:
Age:
Patient telephone number

Primary:

Alternative number:

HCN:
Interpreter required: Yes ☐ No ☐

Referring Clinician:
Referring Trust:

Patient Aware of Diagnosis Yes ☐ No ☐
Patient Aware of referral to Oncology (if required) Yes ☐ No ☐

Copy of MDM report to

Site
Current TMN Staging: T Stage **N Stage** **M Stage**
For information on Head and Neck TNM Staging please consult: http://www.sign.ac.uk/pdf/rocket90.pdf

MRI Date:

CT Date:
PET Date:

Histology
If other specify
MDM co-ordinator copy report to CaPPs ☐

Clinical Summary:

Question to MDM:

Weight

Smoking/alcohol history:

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

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

Submit Form