LUNG MDM REFERRAL FORM

Completed forms must be returned before midday Thursday prior to MDM. Incomplete forms will not be accepted

Patient Name HCN Date of Referral Date of MDM Copy MDM report to CNS aware Yes ☐ No ☐	Referring clinician Referring hospital Patient aware of diagnosis Yes ☐ No ☐

Symptoms at presentation

Cough ☐
Chest infection ☐
Haemoptysis ☐
Hoarsness ☐
SOB ☐
Chest pain ☐
Back pain ☐
Other pain ☐
Fatigue ☐
Neurological ☐

Signs at presentation

SVCO ☐
Collapse ☐
Localised wheeze ☐
Pneumonia ☐
Plural effusion ☐
SCF nodes ☐
Clubbing ☐
Liver Metastasis ☐
Other ☐
Weight
Height
BMI
Percentage weight loss over last three months

Clinical Assessment

Risk Factors:
Smoking status
Per day
Per week pipe
Stop date
Asbestos Details
Weight

Respiratory:
FEV1:
% Predicted
FVC
% Predicted
FEV1/FVC Ratio:

Clinical Summary:

Co Morbidities: COPD ☐ Diabetes ☐ Dementia ☐ IHD ☐ CHF Renal Disease ☐ Hypertension ☐ CVD ☐ PVD ☐
Other Malignancy ☐ Other Condition ☐
Blood thinning medication YES ☐ please list detail NO ☐
Performance Status Stair Climb Distance on flat

Reason for discussion:
Question for MDM/Reason for MDM discussion:
Review: CT ☐ Location: CT FNA ☐ Date
PET ☐ Date Bronchoscopy ☐ Date

Submit form