

Oesophago-gastric MDT Referral Proforma

Patient Name:	QEHB/NHS Number:	D.O.B:
Patient Address:	Patient Tel No:	GP:
Referring Hospital:	Referring Consultant:	CNS:
Referrer Email:	Referrer phone number:	
Referral to QEHB Consultant: Yes No	Name:	
CWT TARGET DATE:	2WW UPGRADE	

Clinical Details: (Include prior treatment, radiology, histology and PMH, current medication):

Performance Status: _____ BMI: _____

Question for MDT:

Is referral for treatment: _____ or MDT discussion only: _____

DIAGNOSIS:	DATE:		
HISTOLOGY:	Location:	Date:	
CT SCAN:	Location:	Date:	
PET-CT:	Location:	Date:	
EUS:	Location:	Date:	

Ensure all histology slides/reports and imaging films/reports are sent with the referral.

Other:

Date Patient agreed to referral to QEHB:

Send completed referral form to UHB-tr.CancerTertiaries@NHS.net

Please note cut off time for inclusion in MDT is Tuesday 12:00hrs

Incomplete forms will result in delays to the patient pathway. Referral will be accepted when all essential information is received.