

SKIN 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
CWT TARGET DATE:	2WW	UPGRADE

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

Performance Status: _____ BMI: _____

Significant Comorbidities:

Question for MDT:

Primary Disease: _____ Metastatic Disease: _____

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

DIAGNOSIS:	SITE:	DATE:
HISTOLOGY:	LOCATION:	DATE:
CT SCAN:	LOCATION:	DATE:
MRI:	LOCATION:	DATE:
PET:	LOCATION:	DATE:
USS:	LOCATION:	DATE:

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

Other:

Date Patient agreed to transfer to QEHB:

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

Please note cut off time for inclusion in MDT is Tuesday 1400hrs

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