

**PATIENT FOR DISCUSSION AT BONE AND SOFT TISSUE TUMOUR MDT MEETING**

Please ensure all sections of the proforma are completed

**External referrals -** [**tnu-tr.sarcomamdt@nhs.net**](mailto:tnu-tr.sarcomamdt@nhs.net) **(you must include a referral letter)**

Internal referrals - [**tnu-tr.sarcomamdt@nhs.net**](mailto:tnu-tr.sarcomamdt@nhs.net)

**The deadline for adding patient’s onto the MDT is 1pm Wednesday.**

Please note, if the proforma has not been filled in with enough detail it will be returned to the referrer.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date patient to be discussed:**  **The MDT is held weekly on a Friday** | | | Click here to enter a date. | | | | | |
| **Patients Name:** | | | Click here to enter text. | | | | | |
| **Date of birth** | | | Click here to enter text. | | | | | |
| **NHS number / NUTH Hospital Number:** | | | Click here to enter text. | | | | | |
| **Consultant:** | | | Click here to enter text. | | | | | |
| **2 Week Wait?** | | Choose an item. | **Target date:** | | Click here to enter a date. | | | |
| **WHO Performance Status** | | | Choose an item. | | | | | |
| **Diagnosis:** | Click here to enter text. | | | | | **Diagnosis date:** | | Click here to enter a date. |
| **Please tick which section patient should be listed:**  Please only tick 1 section, if a patient has never been discussed previously tick ‘New Referral’ | | | Choose an item. | | | | | |
| **Clinical History**  **Please also attach latest clinic letter.**  **Retroperitoneal tumours for which a germ cell tumour is a possibility must have the relevant tumour markers performed.** | | | **.** | | | | | |
| **Patient preferences, patient understanding and relevant social issues that may influence treatment options.** | | | Click here to enter text. | | | | | |
| **RADIOLOGY TO BE REVIEWED AT MDT:**  Please advise what imaging, when and where it is from.  **ONLY COMPLETE FOR RADIOLOGY TO BE REVIEWED IN MDT** | | | Click here to enter text. | | | | | |
| **HISTOLOGY TO BE REVIEWED AT MDT:**  Please advise what histology, when and where it is from.  **ONLY COMPLETE FOR HISTOLOGY TO BE REVIEWED IN MDT** | | | Click here to enter text. | | | | | |
| **Question for MDT:**  (Give details of the question for the MDT meeting, why the patient needs to be discussed) | | | Click here to enter text. | | | | | |
| **Name of person completing form** | | Click here to enter text. | | **Tel Number** | | | Click here to enter text. | |
| **Email address for outcomes to be sent (nhs.net is preferred for security reasons)** | | | Click here to enter text. | | | | | |