

HEAD & NECK 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: _____

Significant Comorbidities: _____

Question for MDT: _____

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

DIAGNOSIS:	DATE:	
HISTOLOGY/CYTOLOGY:	Location:	Date:
THYROID: Thyroid Function:		
USS:	Location:	Date:
FNAC:	Location:	Date:
LARYNX & HYPOPHARYNX:		
CT SCAN (Neck + Chest):	Location:	Date:
NASOPHARYNX, OROPHARYNX, SALIVARY GLAND & ORAL CAVITY:		
MRI:	Location:	Date:
CT SCAN (Neck + Chest):	Location:	Date:

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

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 Monday 12:00hrs

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