

# Stereotactic Radiosurgery MDT Referral Proforma

**NHS England Eligibility criteria:**

- Performance Status 0 or 1.
- Cancer diagnosis with absent or controllable primary disease.
- Pressure symptoms best relieved with surgery are excluded.
- Tumour volume <20cc
- Prognosis > 6 months

**Date Patient agreed to referral to QEHB:**

Patient Name:	QEHB/NHS Number:	D.O.B:
Patient Address:	Patient Tel No:	GP:
Referring Hospital:	Referring Consultant:	CNS:
Referrer Email:	Referrer phone number:	
Date discussed at Local MDT:	Opinion of Local MDT:	
CWT TARGET DATE:	2WW	UPGRADE

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

Current systemic therapy (including date last given):

Dexamethasone:	Dose:	Date started:
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Previous Whole brain radiotherapy?	NO	YES (Give details):
Performance Status:	KPS	BMI:
PROGNOSIS OF 6 MONTHS:	NO	YES

Significant Comorbidities:

Is primary site controlled?	NO	YES
Extracranial metastatic disease?	NO	YES (is it controllable?):

Question for MDT:

Is referral for treatment: \_\_\_\_\_ or MDT discussion only: \_\_\_\_\_

HISTOLOGICAL DIAGNOSIS:	Location:	Date:
MRI (Brain with contrast){within 4/52}:	Location:	Date:
Other:		

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

**Send completed referral form to [UHB-tr.CancerTertiaries@NHS.net](mailto: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.