

## URO-ONCOLOGY MDT Referral Proforma – **TESTICULAR**

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):

Performance Status: \_\_\_\_\_ BMI: \_\_\_\_\_

Significant Comorbidities:

Question for MDT:

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

DIAGNOSIS:	DATE:
ORCHIDECTOMY:	Location:                      Date:
HISTOLOGY:	Location:                      Date:
USS:	Location:                      Date:
CT SCAN – Chest/abdo/pelvis:	Location:                      Date:
<b>Ensure all histology slides/reports and imaging films/reports are sent with the referral.</b>	
Pre-op Tumour Markers:	Location:                      Date:
AFP:	HCG:
<b>Date Patient agreed to transfer to QEHB:</b>	
<b>Send completed referral form to <a href="mailto:UHB-tr.CancerTertiaries@NHS.net">UHB-tr.CancerTertiaries@NHS.net</a></b>	
<b><u>Please note cut off time for inclusion in MDT is Wednesday 12:00hrs</u></b>	
<b>URGENT VERBAL REFERRALS ARE APPROPRIATE IF THE PATIENTS ARE:</b>	
1. Unwell	2. Have multiple lung metastasis
3. Have AFP >1,000 ng/ml	4. Or HCG >5,000 iu/ml
5. Renal obstruction	
<b>A telephone referral should be made to:</b>	
<b>Dr Porfiri's registrar via switch 0121 627 2000 or Paul Hutton CNS on 0121 371 4509 / 07789 932 836</b>	

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