Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

TYA Late Effects MDT Referral Proforma

Please note: in order to have a meaningful discussion about this patient at the Late Effects MDT, it is important to complete all sections of this form as fully as possible.

Patient Details

Patient name:

QEHB/NHS number:

DOB:

Biological sex:

Preferred gender:

Ethnicity:

Patient address:

Patient telephone number:

GP:

NOK:

NOK telephone number:

Referring hospital:

Named consultant:

Referring professional (name and role):

Referrer email:

Referrer telephone number:

Date:

Diagnosis Details

Diagnosis:

Date of diagnosis:

Clinical details:

Patient fitness and co-morbidities:

Treatment Details

Please add a detailed background of treatment given. To be added to this MDT it is necessary for us to have the below information:

- Treatment plan
- Consented on a trial
- Cumulative doses of treatment
- Radiotherapy fields
- Name of consultant
- Place the treatment was given

Please note we would also accept an end of treatment summary in place of this information.

Chemotherapy:

Radiotherapy:

Surgery:

Other (please specify):

End of treatment details

Date of end of treatment (please state if N/A):

Date when started maintenance:

For advice only referrals

Please complete if patients are not eligible for the Survivorship Service and requiring advice only for the patient from the Late Effects MDT

Follow up post-treatment *(Please state any expected post-treatment investigations i.e. scans, echos etc.)***:**

Question to MDT *(Please state reason for referral)***:**

Specific considerations for Survivorship Service Referral only

(Only answer if the patient requires to be referred to the Survivorship Service)

Is the patient aware of the referral? Yes ◯ No ◯

If "No", please add the reason (i.e. medical reasons/eligibility):

Have they consented to be contacted by the Survivorship Service? Yes ◯ No - declined ◯

(It is not required to answer the below questions)

What type of support did the patient require whilst on treatment?

Has the patient engaged with the Youth Support Coordinator? Yes ◯ No ◯

If "Yes", have they attended events organised by YSCs? Yes ◯ No ◯

Has the patient received fertility preservation? Yes ◯ Declined ◯ Not eligible ◯

If "Yes", please provide full details of preservation *(i.e. date and type of preservation)*:

Additional information

Please state any other information you believe to be relevant for service

Please send completed referral forms to: TYAMDT@uhb.nhs.uk

Queries should be directed to the QEHB TYA Survivorship Clinical Nurse Specialist (Monday to Thursday) via mobile on **07467 461 492** or via email on TYASurvivorship@uhb.nhs.uk.

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