Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

TYA Psychosocial MDT Referral Proforma

Please Note: In order to have a meaningful discussion about this patient at the TYA MDT, it is important to complete **all** sections of this form as fully as possible.

Patient Details

Patient Name:	QEHB/NHS Number:	D.O.B:
Patient Address:	Patient Tel No:	Ethnicity:
GP:	NOK:	NOK Tel No:
Referring Hospital:	Named Consultant:	Referring Professional (name & role):
Referrer Email:	Referrer Tel No:	Date:

Diagnosis Details

Diagnosis: Date of diagnosis:

Clinical details: (include prior treatment, radiology, histology and PMH):

Histology:	Location:	Date:
Imaging:	Location:	Date:

Patient fitness and co-morbidities (including any history of previous malignancies):

Clinical Trials

Is there an applicable clinical trial:	Yes: ◯ No: ◯	Name of trial:
Has the TYA been consented:	Yes: ◯ No: ◯	If no, please confirm the reason for non-recruitment:

Treatment Plan

Treatment details:	Responsible Consultant:	Place of Treatment
Chemotherapy		
Radiotherapy		
Surgery		
Palliative care		
Other (Please specify)		

TYA Specific Considerations

Is TYA aware of diagnosis:	Yes: ◯ No: ◯	If No, why?
Is TYA aware of referral:	Yes: ◯ No: ◯	If No, why?
Has TYA been offered the choice to have Treatment at QEHB?:	Yes: ◯ No: ◯	If No, why?

TYA Specific Considerations continued:

Have fertility issues been discussed with the TYA?:	Yes: ◯ No: ◯	If No, why?
TYA Specific information provided?:	Yes: ◯ No: ◯	Please detail:
Is a fertility preservation referral required?:	Yes: ◯ No: ◯	
Has TYA been offered the opportunity to tissue bank?:	Yes: ◯ No: ◯	If No, why?

Outcomes (For PTC TYA MDT use only)

Date of referral to TYA MDT:	Date of discussion at TYA MDT:	
Case discussed within 7 working days:	Yes: ◯ No: ◯	If No, why?
Have any significant psychosocial needs been identified and discussed (i.e. education, finances, social/family history, psychosocial history)?:	Yes: ◯ No: ◯	Please provide detail:
TYA holistic needs identified and subsequent supportive care plan fed back to the Consultant and treating team?:	Yes: ◯ No: ◯	If No, why?
TYA Keyworker allocated?:	Yes: ◯ No: ◯	Named TYA Keyworker:
Contact made with the TYA?:	Yes: ◯ No: ◯	
Referral & allocation to the CLIC Sargent Team?:	Yes: ◯ No: ◯	Named YP Social Worker:
Contact made with the TYA?:	Yes: ◯ No: ◯	
TYA disease specific information provided?:	Yes: ◯ No: ◯	If No, why?
Is there agreement between the site specific and TYA MDT?:	Yes: ◯ No: ◯	If No, why?
TYA MDT discussion outcome provided to the relevant referring and treating teams within 7 working days of the TYA MDT.	Yes: ◯ No: ◯	If No, why?

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

Please note the cut off time for inclusion in MDT is Monday 12:00hrs

Queries should be directed to the QEHB TYA CNS Team via: Main Office (Monday to Friday): 0121 371 6237 or mobiles: 07771 346 103/07785 657 586

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