Office use only:

Imaging IEP’d [ ]

Accepted [ ]

Redirected [ ]

Document Only [ ]

Requires more information – defer [ ]



|  |
| --- |
| **Request for discussion at the Imperial Neurooncology Multidisciplinary meeting** |
| **PLEASE ANSWER ALL QUESTIONS ON BOTH PAGES.** **PLEASE ENSURE ALL THAT ALL RELEVANT IMAGING IS IEP’D TO IMPERIAL.****REFERRALS WITH INCOMPLETE INFORMATION OR NO IMAGING WILL NOT BE DISCUSSED****Please complete electronically and email to** imperial.braincns.mdt@nhs.net. **The meeting is held weekly on Wednesday from 3-5pm. The cut off for accepting additions is 12pm Monday. For urgent cases after this deadline please discuss with neurosurgical SpR on call 07425611809 (0800-1700) or 07836589175 (1700-0800)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of referral** | Click to enter date | **Hospital** |  |
| **Patient Name** |  | **If Imperial:** | **Ward:**  |
| **DOB** |       |  | **MRN:**  |
| **NHS Number** |  | **Your name:** **Your designation:** Choose a designation**Email:****Bleep/Mobile:**  |
| **Patient tel** |  |
| **Lead Clinician details:** | **Name:**  |
| **Email:**  |
| **Tel:**  |  |
| **Neurosurgery on call referral:** Choose an item.**Date:** Click to enter a date.**Registrar/Consultant you spoke to:**  |

|  |
| --- |
| IF A PATIENT HAS A HISTORY OF CANCER THEN REFERRAL MUST BE SUBMITTED BY OR IN CONJUNCTION WITH THEIR TREATING ONCOLOGIST**Oncology status:** Choose an item.Name and location of treating oncologist:      Details of previous cancer diagnosis:      Oncology treatment including dates given. If previous cranial radiotherapy or SRS/gamma knife please include dates and sites irradiated:      Future treatment plan:      Prognosis:       |
| **BRIEF HISTORY OF PRESENTING COMPLAINT**  |
| **Question for MDT:**  |
| **IMAGING** *Please include summaries of reports or email reports with proformas*Image IEP to ICHCT requested Yes [ ]   |
| MRI head Yes [ ]  No [ ] All patients require a MRI head with contrast unless contraindicated | Date:      Summary of report:       |
| If MRI head not performed because of contraindication above:CT head Yes [ ]  No [ ]  | Date:      Summary of report:        |
| CT CAP Yes [ ]  No [ ] All patients with suspected or known metastatic brain lesion require a CT CAP. The report is imperative. Patient will not be discussed in MDT if report is not provided. | Date:      Summary of report:            |
| **OTHER IX** (LP, Bloods, CXR etc if relevant):       |
| **NEUROONCOLOGICAL SURGICAL PROCEDURE** (if any):       |
| **CURRENT PERFORMANCE STATUS\*:** Choose an item.\* ECOG Performance Status Scale. Developed by the Eastern Cooperative Oncology Group (ECOG), now the ECOG-ACRIN Cancer Research Group, and published in 1982. To learn more, visit [ecog-acrin.org/scale](https://ecog-acrin.org/scale) |
| **PMHx:**      |
| **CURRENT MEDICATIONS**Steroid Treatment: Yes [ ]  No[ ] Please note any recent change to steroid dose or regimen:      Anti coagulants, including antiplatelets: Yes [ ]  No[ ]  If yes please specify:      Anti seizure medication: Yes[ ]  No[ ]  If yes please specify:      Other medications:      |
| **Current neurological status if relevant** *(GCS/pupils/focal neurology)*      |
| **Any additional information:**      |

Outcome from this MDM will be emailed to you within 24h of discussion. All urgent action will be relayed personally by one of our team.

By using this form you agree that you or a responsible practitioner of sufficient seniority will convey the MDM decision to your patient/their next of kin.