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| **East of England Lynch Syndrome Expert Network (EELSEN)** **MDT Referral Form**Email: cuh.lynchsyndromenetwork@nhs.net 1. Please ensure all parts of this form are filled in. Forms submitted with minimal clinical information will not be accepted and returned to you. If you are sending this referral incomplete for any reason, a conversation from your consultant to ours needs to have taken place beforehand.
2. Please attach one referral form per email when referring to any MDT.
3. Please ensure you send all relevant imaging/histology required for review at the MDT.
4. Please do not attach reports at the bottom of this referral. These can be attached to the same email.
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| **Referring Hospital** | Referring Trust |
| **Referring Clinician** | Referring Clinician  |
| **MDT Co-ordinator name** | First Name Surname |
| **MDT Co-ordinator phone number** | Telephone number  |
| **MDT Co-ordinator email address** | Email address  |
| **PATIENT INFORMATION** |
| **Patient Name** | First Name Surname |
| **NHS Number** | 0 |
| **Date of Birth** | Date of Birth |
| **Address** | Address Line 1Address Line 2 Address Line 3 Post code  |
| **Telephone Number (home)** | Telephone Number (Home)  |
| **Telephone Number (mobile)** | Telephone Number (Mobile)  |
| **GP Name/Address** | GP Name Practice Name Address Line 1Address Line 2 Address Line 3 Post code  |
| **Is this an NHS or Private Patient?** | Choose an item. |

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| **MDT INFORMATION** |
| **Cancer Status (provide details in end column)** | No cancer [ ]  | Additional information |
| Previous cancer/s [ ]  | Additional information |
| Current cancer Treatment [ ]  | Additional information |
| **Timing of Discussion** | Reason for DiscussionIf discussion is urgent enter desired timeframe and reason here:Click here to enter text. |
| **Reason for Discussion** (tick all that apply) | Screening [ ]  | Additional information |
| Risk Management [ ]  | Additional information |
| Joint Surgery [ ]  | Additional information |
| Other [ ]  | Additional information |
| **Suggested MDT input required** (as a minimum, others may be involved) tick all that apply | Genetics [ ]  | Additional information |
| Gynaecology [ ]  | Additional information |
| Colorectal [ ]  | Additional information |
| Upper GI [ ]  | Additional information |
| Gastroenterology [ ]  | Additional information |
| Oncology [ ]  | Additional information |
| Other [ ]  | Additional information |
| **Question for MDT** | **(please provide specific question for the MDT address**)Question for MDT |
| **Request for CUH to consider taking over the patient’s care?** | ***\*All patients remain under the primary care of the referrer. MDT may consider offering to take over the care if appropriate, but will require agreement by the MDT, followed by formal referral through the relevant pathway.***Choose an item. |
| **CLINICAL INFORMATION** |
| **Genetic variant** | Choose an item. |
| **Family Number** **(if known)** | Family Number  |
| **Family History/Pedigree (submit with referral possible):** Family History/Pedigree |
| **Clinical context (relevant past history / key issues identified by referrers):***MDT can only consider the information provided by the referrer* | Additional information |
| **Have the findings been shared with the patient? What is their view on options/treatment/next steps?** | Click here to enter text. |