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| **Neuroscience Spinal MDT Referral Form v1**   |  |  | | --- | --- | |  | **PLEASE COMPLETE FULLY THIS REFERRAL FORM FOR ALL PATIENTS.**  **PATIENTS WILL NOT BE PLACED ON THE MDT LIST WITHOUT A COMPLETED FORM.**  **SEND COMPLETED REFERRAL FROM TO**  [**uhsussex.brightonneurocancermdmcoordinator@nhs.net**](mailto:uhsussex.brightonneurocancermdmcoordinator@nhs.net) | | | | | |
| **Patient Details** | | | | |
| Forename |  | Consultant | |  |
| Surname |  | Hospital | | Choose an item. |
| Date of Birth |  | IP/OP/Location | |  |
| Age |  | NHS/Hospital number | |  |
| **Presentation (including neurological symptoms and signs):** | | | | |
| **Relevant Co-Morbidities** (including any H/O cancer): | | | | |
| **Prognosis:** | | | | |
| **Previous spinal RT:** Choose an item.  **Dates & levels treated:** | | | | |
| **Current systemic anti cancer therapy:** | | | | |
| **Medication:**  Antiplatelets/Anticoagulants (Indication)Choose an item. Other:  Anticonvulsants:  Steroid/dose:  Other relevant medications: | | | | |
| **WHO Performance status** : Choose an item. | | | | |
| **Tokuhashi Score (see next page for details):** | | | | |
| **Radiology / Investigations** | | | | |
| CT Scan Choose an item. | | Date: | | |
| MRI Scan Choose an item. | | Date: | | |
| CTCAP/PET Choose an item. | | Date: | | |
| **Questions for MDT?** | | | | |
|  | | | | |
| Referred to the MDT by:  Email Address of referrer |  | Date of referral: |  | |
| Email address MDT outcome to be sent to (if different): |  |  |  | |

