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| **Tumour Group** Choose an item. | **BH Cancer Referral Package Checklist** | | |
| **Referred for First treatment?** | Click here to enter a date. | **Referred for Subsequent treatment?** | Click here to enter a date. |
| **MDT discussion & transfer of care** | Choose an item. | **MDT discussion only** | Choose an item. |
| **Cancer Referral (2WW)** | Choose an item. | **Upgrade referral** | Choose an item. |

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| **PATIENT INFORMATION** | | | |
| **Patient Name** |  | **Patient Address** |  |
| **NHS Number** |  |
| **Patient DOB** |  |
| **Contact Number** |  | **GP Address** |  |
| **GP Name** |  |

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| **CANCER WAITING TIMES INFORMATION** | | | | | | | | | |
| **Priority Type** |  | | | | | | | | |
| **Breach date** | Click here to enter a date. | **Is this referral the:**  Start of a new pathway - (New condition or change of treatment) □  Continuation of an active pathway – (1st definitive treatment not given) □  Continuing treatment for a stopped pathway – (1st definitive treatment given) □  Currently being actively monitored (1st definitive Treatment given) □ | | | | | | | |
| **GP Referral decision date** | Click here to enter a date. |
| **First Seen date** | Click here to enter a date. |
| **Date referral received** | Click here to enter a date. | **Source of Referral** |  | | **Latest**  **MDM date** | | Click here to enter a date. | | |
| **Referral Method** |  | **Decision to treat date** | | Click here to enter a date. | | | | | |
| **Primary Diagnosis (ICD-10 code)** |  | **Recurrence cancer?** | | | | Yes |  | No |  |
| **REFERRAL DETAILS These fields are Mandatory\*** | | | | | | | | | |
| **Referred to Barts Health for:**  **NB Please state procedure** | **Surgery** |  | **Diagnostic Tests** | | | Choose an item. | | | |
| **Chemotherapy** |  | **Required Test MRI/CT/PET/USS/Bone Scan** | | | *Delete as appropriate* Choose an item. | | | |
| **Radiotherapy** |  | **Second Opinion** | | |  | | | |
| **MDT** **Discussion**: **Question** |  | | **Proposed MDT Discussion Date** | | | Click here to enter a date. | | | |
| **MDT Co-Ordinator**  **[Name and Email Address]**  **Phone** |  | | **Referring** **Trust** | | | Choose an item. | | | |
| **Date Referral Package Emailed:** | Click here to enter a date. | | **Referring Clinician** | | |  | | | |

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| **SURGICAL REFERRAL CONSULTANTS** | |  | **ONCOLOGY REFERRAL CONSULTANTS** | |
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| **REFERRAL PACKAGE These fields are Mandatory\*** | | YES or N/A | **Comments** | |
| **Copy of GP Referral** | | Choose an item. |  | |
| **MDT Proforma** | | Choose an item. |  | |
| **Referral Letter** | | Choose an item. |  | |
| **Recent & previous Mammograms** | | Choose an item. |  | |
| **Copies of relevant histology report** | | Choose an item. |  | |
| **Recent & previous Chest Xray, Bone Scan and Liver Ultrasound** | | Choose an item. |  | |
| **Other: [CT Chest/ Abdomen]** | | Choose an item. |  | |