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| **The Royal Orthopaedic Hospital Bone Tumour Service – Tertiary Referral Form**  |
| **Incomplete forms will result in delays to the patient pathway. Referral will be only be accepted when all essential information is received** |
| **REFERRING TRUST** |  |
| **Cancer Tracker name****Cancer Tracker Telephone number****Cancer Tracker email** |  |
| **Patient Name** |   |
| **Date of birth** |   |
| **Gender** |   |
| **NHS Number** |   |
| **Mobile number** |   |
| **Home number** |   |
| **Address** |   |
| **Postcode** |   |
| **If inpatient, please state ward and hospital location** |  |
| **If Interpreter is required, please provide native language** |   |
| **If yes, what language?** |   |
| **Is this patient on a cancer waiting times pathway? Please state 2ww or Upgrade** |  |
| **What is the patient’s CWT treatment target date?****Date Referral Received:****Date first Seen:****Diagnosis Date (if applicable):** |  |
| **What is the reason for your referral?** **Please indicate ‘Y’** | **Suspected bone sarcoma** |  |
| **Suspected soft tissue sarcoma** |  |
| **Benign bone tumour** |  |
| **Benign soft tissue tumour** |  |
| **Metastatic bone disease** |  |
| **Please confirm the Patient been advised of this referral?** |  |
| **Have you referred this patient to any other provider?****(Please update us if this changes)** |   |
| **Referrer information:** |  |
| **Name and GMC Number of Consultant responsible for the patient** |   |
| **Consultant/Secretary contact number (to enable our consultant to discuss patient following MDT)** |  |
| **Consultant/Secretary email address** |  |
| **Name of Doctor completing form****Job title** **GMC Number** |  |
| **Mobile number** |  |
| **Have you attached additional information along with this form? If so, please describe** |  |
| **Referring Organisation Address** |  |
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| **Please confirm all relevant images sent by IEP Yes/No?** |   |
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| **Previous Imaging** |
| **Date**(MM/YY) | **Modality**(MR/CT/XR/US/NM) | **Body Area & Laterality** | **Organisation where imaging performed** |
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| **Please provide all previous imaging reports** |  |
| **IEP transaction number (s)** |  |
| **IEP transaction number (s)** |  |
| **IEP transaction number (s)** |  |

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| **Other Relevant information:** |
| **Co-morbidities, please include all** |   |
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| **Anticoagulants: warfarin / clopidogrel / Other new oral anticoagulant.** |   |
| **If Warfarin please provide date and detail of recent INR in this freetext box** |   |
| **Current medication** |   |
| **Bloods: Must be provided for suspected primary bone malignant tumours and metastatic bone disease referrals.** |
| **Hb** |   |
| **Adj Ca++** |   |
| **Alb** |   |
| **U+E** |   |
| **LFT** |   |
| **Clotting** |   |
| **Key Clinical Information – reasons for referral:** *For example, weight loss, night pain, lumps increasing in size, prior history of cancer.* |
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Select ONE of the following:

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| First treatment |  | **MCj03540590000[1]** | **MDT ALERT TO INCOMING PATIENT** |
| Subsequent treatment |  |
| Recurrence  |  |  | **To be sent to: MDT Co-ordinator**  | **Trust Royal Orthopaedic**  |
| Was this a: |  |  | **Tertiary cancer alert Email:** | **Rohoncology.referrals@nhs.net**  |
| Consultant upgrade | □ |  | **From:** (person sending this email and email address) |  |
| Upgrade date |  / / | **Trust:** |  |
| PPI |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | **Tel:** |  |
|  |  |
|  |  |
| **Patient Details** |
| Forename |   | Surname |   | DOB |   |
| NHS Number |   | Hospital Number (Referring Trust) |   |
| Address |   |
| **Is the patient aware of the diagnosis?** |   | Patient Tel. No. |   |

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| **Referral Details** |
| GP 2 week Referral (suspected cancer or breast symptoms) |   |  Date of receipt of GP 2 week referral (suspected cancer or breast symptoms) |  / / |
| GP name (Referring) |   | GP Phone |   |
| GP Practice name |   | Trust First Seen |   |
| Date First Seen |  / / | Date discussed at MDT meeting |  / /  |
| Decision to Treat Date (Date discussed and agreed with patient) |  / / | Earliest Clinically Appropriate Date (ECAD) |  / / |
| Clinician (Referring) |   | Speciality |   |
| Clinician Referred to at Cheltenham  |   | Speciality |   |
| Has a referral letter together with imaging/histology reports been sent to clinician? If No please arrange.  |   |
| Referred for Treatment |   | Planned Treatment Type | Surgery/ Chemotherapy/ Radiotherapy/ Palliative Care/ Brachytherapy |
| Referred for Diagnosis |   |
| Diagnosis Confirmed |   | Tumour Type (Diagnosis) |   |
| Date of clinical intervention which confirmed cancer (date of diagnosis) |   |
| Reasons for Delay in meeting target(s)  |  |
| Pause(s)(No. of days) |  | Reasons for Pause(s) |  |
| **Target Treatment Date** | Potential 31 day target  |
| *This document is not intended to replace the clinical referral letter.* |
| **Office Use Only** |
| Date Received | / / | Date OPA | / / | Clinic Code | / / |