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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** |  | | |
| |  |  | | --- | --- | | **Please confirm all relevant images sent by IEP Yes/No?** |  | | |  |  |  |  | | --- | --- | --- | --- | | **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:** |  | | |
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| **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 | | | | | | / / |