Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

HEAD & NECK MDT Referral Proforma

Patient Name:	QEHB/NHS Number:	D.O.B:
Patient Address:	Patient Tel No:	GP:
Referring Hospital:	Referring Consultant:	CNS:
Referrer Email:	Referrer phone number:	
Referral to QEHB Consultant: ◯ Yes ◯ No	Name:	
CWT TARGET DATE:	◯ 2WW ◯ UPGRADE	

Clinical Details: (Include prior treatment, radiology, histology and PMH, current medication):

Performance Status: BMI:

Significant Comorbidities:

Question for MDT:

Is referral for treatment: ◯ or MDT discussion only: ◯

DIAGNOSIS: DATE:

HISTOLOGY/CYTOLOGY: Location: Date:

THYROID: Thyroid Function:

USS: Location: Date:

FNAC: Location: Date:

LARYNX & HYPOPHARYNX:

CT SCAN (Neck + Chest): Location: Date:

NASOPHARYNX, OROPHARYNX, SALIVARY GLAND & ORAL CAVITY:

MRI: Location: Date:

CT SCAN (Neck + Chest): Location: Date:

Ensure all histology slides/reports and imaging films/reports are sent with the referral.

Date Patient agreed to transfer to QEHB:

Send completed referral form to
HandNMDTRequests@uhb.nhs.uk

Please note cut off time for inclusion in MDT is Monday 12:00hrs

Incomplete forms will result in delays to the patient pathway. Referral will be accepted when all essential information is received.

Email form Save form