Patient Management Information Form for Spinal Oncology Referrals to UHW

***Telephone and speak to spinal surgery/trauma SpR on-call or Consultant at UHW – contact via* UHW Swithchboard (029 20747747 or 0-1872-100)**
they will give you the fax number to which this form should be sent
Please complete as fully as possible and ***FAX***

Date and Time of Referral:-
An acknowledgement will be faxed back, please give the fax number:
Emergency Referral (phone call already made)/Referral for urgent opinion* *Delete as appropriate*

Patient Details	**Referring Consultant/GP/Oncologist**
Surname Forename D.O.B. Gender Address Postcode Telephone No NHS No In / Out Patient Hospital and Ward Direct Dial Number	Consultant/GP Contact No (Mobile) Oncologist (If already diagnosed) Contact No (mobile) Is Oncologist aware of referral Y / N **Current Relevant Co-morbidities** None 1 2 3 4 **Hb Ca++ Alb** **Is patient anticoagulated?** Y / N
Tumour Presentation (circle provisional diagnosis) Previous known primary: probable mets Previous unknown primary; probable mets Probable musculo-skeletal primary Probable intradural primary Estimated prognosis >3 months Y/N/not known **Biopsy** Y/N Result Date	**Prior Discussion at MDT** Y / N Hospital Date Group **Patient understanding** Has diagnosis and possible surgery been discussed with patient? Y / N **What information has been given to the patient?** Does Patient wish to consider surgery? Y / N

Please send all available imaging and copies of reports
PLEASE COMPLETE NEXT PAGE

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Patients Name:	**DOB**

TUMOUR	**SPINE**
Primary *(circle disease site)* Bronchus Breast Prostate Renal Thyroid Myeloma Lymphoma Uterine/Cx Melanoma GIT GU Unknown Other (specify) Date of diagnosis:	**Presenting Complaint** None Pain only Y / N since (date) Location; Type: Non specific Mechanical Postural Pattern: Nocturnal Diurnal Constant Neurological Symptoms Y / N since (date) Neurological Signs Y / N since (date)
Primary Rx	
Adjuvant Rx 1 2 3	**Walking Status** Normal Unsteady since (date) Not ambulant since (date)
Previous Metastases Y / N Define **Current Staging** **Osseous Mets** Y / N demonstrated by: Isotope scan -date / Not done Plain Radiographs -date / Not done Sites:-	**Incontinence** Urinary Y / N since (date) Faecal Y / N since (date) **Sensory Level** Y/N Define Since **Lowest MRC* grade** 0 1 2 3 4 5 Muscle Group(s) Since **MRI (whole spine)** Yes / Not done Location Date Time
Visceral Mets Y / N demonstrated by: CT Chest /Abdo -date / Not done Liver US -date / Not done	CXR -date / Not done Sites:-
Other relevant information	
Details of clinician responsible for ongoing care of the patient following surgery.	
Name:-	Contact Number:-

This form may be used for **urgent referrals** or cases you wish to discuss/present at Friday am Spinal MDT@ UHW