Thames Valley Cancer Network

Berkshire, Buckinghamshire, Oxfordshire, Swindon

Referral Form for Management of Spinal Oncology Patients

Please telephone this referral through to the receiving team as this proforma may not be seen until the following morning.

Please complete as fully as possible (by the acute admitting team) then contact the On-Call Oncology SpR at Churchill Hospital on 01865 572140 Mon-Fri 9am-5pm or Out of hours via the Churchill Switchboard number 01865 741841.

Date of Referral:	**Time of Referral:**
Oncology Registrar case discussed with: ***Fax number : 01865 235956***	
Emergency Referral (phone call already made) / Referral for urgent opinion* *Delete as appropriate*	

Patient Details (or affix label)	**Referring Consultant / GP / Oncologist**
Surname: Forename: D.O.B. Address: Postcode: Telephone No. (home) (mobile) NHS No. Gender M / F 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	**Prior Discussion at MDT** Y / N **MDT at which hospital?** **Date:**
Estimated prognosis >3 months Y/N/not known	**Patient understanding:** Has diagnosis and possible surgery been discussed with patient ? Y / N Does patient wish to consider surgery? Y / N / Don't know Has an information booklet been provided for the patient? Y / N Has an information booklet been provided for the carer? Y / N Visit Trust Intranet.
Biopsy Y / N Result Date	

Please send all available imaging and copies of reports

Patient Management Information Form for Spinal Oncology Referrals

Patients Name: **(or affix label)**	**D.O.B.**

TUMOUR	**SPINE**
Primary (circle disease site) Bronchus Breast Prostate Renal Thyroid Myeloma Lymphoma Uterine/Cx Melanoma GI GU Unknown Other 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	
Previous treatments for cancer 1 2 3	**Walking Status/Chronology of Neurological deterioration :** Last walked normally date: Unsteady since (date): Not ambulant since (date):
Previous Metastases Y / N Define **Current stating** **Osseous Mets** 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 (date)
	MRI whole spine) Yes / Not done Date: Time: Location

Visceral Mets Y / N Demonstrated by: CT Chest/Abdo date / Not done CXR date / Not done Liver US date / Not done Sites:
Other relevant information:
Details of clinician responsible for on going care of the patient following surgery.

Name:	**Contact Number:**