|  |  |  |  |
| --- | --- | --- | --- |
| **Multi-Disciplinary Meeting Report**  **Gynae Oncology** | | | |
| **Date of Referral** | {referralDate} | | **NHI Number** | | {nhi} | |
| **Patient Name** | {patientName} | | | **DOB** | {dob} | | |
| **Address** | {address} | | |  |  | | |
| **Phone/ Mobile** | {phone} | | |  |  | | |

**REFERRING SPECIALIST**

* Consultant name: {referrerName}
* Hospital/DHB: {referrerDHB}
* Email address: {referrerEmail}

**GP name and address:** {gp}

**HISTORY**{#bullets}

* {label}: {value} {/bullets}

**{#hasRad}**

**RADIOLOGY{/hasRad}**{#radiology}

* {radType}, {radDate}{radDHB}
  + Findings: {radFindings}{/radiology}

**{#hasOp}**

**OPERATION{/hasOp}**{#operation}

* {opType}, {opDate} {opSurgeon}
  + Findings: {opFindings}{/operation}

**{#hasHisto}**

**HISTOLOGY{/hasHisto}**{#histology}

* {histoType}, {histoDate}{histoDHB}
  + Findings: {histoFindings}{/histology}

**MDM QUESTION** {question}

**REVIEW**

**DIAGNOSIS**

**GENETICS REFERRAL REQUIRED? Y/N**

**RECOMMENDATIONS**