

**Wessex Teenagers & Young Adults MDT Request Form**

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| **Dr. Andrew Davies, Lead Clinician**Mobile: 07976 815095 | **TYA MDT Co-ordinator**Tel: 023 81 204605 Please send referrals to **TYANURSES@uhs.nhs.uk** **&** **TYAMDT@uhs.nhs.uk** |
| **Jo Grout, TYA Lead Nurse**Tel: 023 81 206556 Mobile: 07920 708343 |

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| Form submitted by: | Tel: | Fax: |
| Trust: | Post held: |
| Date submitted: | nhs.net email: |

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| **PATIENT DETAILS** | **GP DETAILS** |
| Name: | Name of GP: |
| NHS No. | Address: |
| Date of Birth: | Postcode:  |
| Address: | Telephone: |
| Ethnic origin: | Fax: |

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| Diagnosis: | Date of diagnosis: |
| Treatment plan: | Treatment start date: |
| Place of care: | Treatment at SUHT/TYA unit offered (19 yrs +) : Y/N  |
| Clinical Trial offered: Y/N Outcome: | Discussion re fertility: Y /N Outcome: |
| Named consultant: | Consultant speciality: |
| Keyworker: | Keyworker contact info: |

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| HNA completed: Y/N Comments: | Referral made to CLIC Sargent: Y / N |

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| **PLEASE FAX/EMAIL THIS REQUEST FORM ALONG WITH THE FOLLOWING:*** Last clinic letters
* HNA
* Site specific MDT outcome
* Imaging reports
* Histology reports

**For discussion at Fridays MDT meeting all information must be complete and received by Thursday 5pm*****(please note that we will not be able to fully process incomplete referrals)*** |

**Office use**
Date received:…………………………….
Date acknowledged:……………………………