COMPLEX SPINE MDT REFERRAL FORM

To be completed for all referrals and sent to MDT coordinator prior to meeting

chloe.handscombe@nhs.net **Fax no: 0114 226 8509***Tel no: 0114 27126 66*

Patient details	Name:		
	Address:		
	NHS No:	DoB:	Date of referral:
Consultant			
Patient's location	**Home**	Hospital…… Ward……	
Site	**Cervical**		
Suspected diagnosis			
Questions to MDT			
Brief clinical history and clinical examination findings			
Neurological status			
Duration of symptoms			
Significant co-morbidities.			
Performance score.	**WHO Performance status** (circle most appropriate): 0 Normal Activity 1 Capable of Light Work 2 Self-caring, up >50% of day 3 Limited Self-care, up <50% of day 4 In bed		
Treatment received	**Medication** **Is patient currently on?** Aspirin Yes/ No Warfarin Yes/No Dexamethasone Yes/No - Dose		
Referral made by:	**Name** …… **Hospital** …… **Contact Nr:**…… **Clinical Referral Letter attached? Yes** ☐ **No** ☐		

Please send the completed and signed referral form to:

chloe.handscombe@nhs.net *or fax to* ***0114 2268509 Phone 0114 27126 66***