**Salisbury IBD/Biologic MDT Referral Proforma**

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| PATIENT DETAILS (Or use Patient Label)  Patient Name:  Hospital No:  NHS Number:  Named Consultant: | Requested By: Position:  Bleep/Tel: Date: |

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| **What question would you like the MDT to answer? : e.g., Treatment, diagnosis, surgery**  **Does this patient require any of the following specific review/discussion?**  **Radiology**  **Medical Management**  **Surgical Management** | | | | |
| **Presenting Symptom**  **Weight Loss:** Yes / No  **Current Weight**:…….…..…….…kg **Amount Lost**:…………………kg **Time period**:…………....…weeks/months | | | | |
| **Past Medical History/Co Morbidities**: (Fitness for treatment/surgery) | |  |  |  |
| **Working Diagnosis:**  **Site:** | | | | |
| **Performance Status:** 0 1 2 3 4  **Smoking history**: Current Ex Never | * 0 – Fully active. * 1 – Symptomatic but capable of light work * 2 – Symptomatic, independent in ADLs, up an about >50% of the day. * 3 – In bed >50% of the day, requiring help with ADLs * 4 – Bedbound | |  |  |

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| **Investigations and results: F Cal – Date: Result:**  **LFT:**  **FBC:**  **CRP:**  **UEC:**  **Haematinics: Biologic screen** | EUS – date:  MRI - date:  MRI – date:  MRCP - date:  CT – date:  Colonoscopy- date:  Flexi – date:  Biopsy – date:  Other (Please Specify) – date: |
| **Additional information:** | |

**All fields of this referral form must be completed prior to discussion.**

**Please be advised that this is a request for discussion only.**