Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

ADRENAL MDT Referral Proforma

Patient Name:	QEHB/NHS Number:	D.O.B:
Patient Address:	Patient Tel No:	GP:
Referring Hospital:	Referring Consultant:	CNS:
Referrer Email:	Referrer phone number:	
Referral to QEHB Consultant: ◯ Yes ◯ No	Name:	
CWT TARGET DATE:	◯ 2WW ◯ UPGRADE	

Clinical Details: (Include how adrenal lesion was detected, tumour size, prior treatment, radiology, histology and PMH):

Performance Status: BMI:

Significant Comorbidities:

Question for MDT:

Is referral for treatment: ◯ or MDT discussion only: ◯

SUSPECTED DIAGNOSIS:	DATE:	
HISTOLOGY:	Location:	Date:
ABDO CT SCAN with pre-contrast adrenal images:	Location:	Date:
ABDO CT SCAN with post contrast images:	Location:	Date:
MRI with chemical shift:	Location:	Date:
MRI without chemical shift:	Location:	Date:
PET-CT:	Location:	Date:

Ensure all histology slides/reports and imaging films/reports are sent with the referral.

Please specify results of any endocrine investigations to date:

Date Patient agreed to transfer to QEHB:

Send completed referral form to AdrenalMDTRequests@uhb.nhs.uk

Please note cut off time for inclusion in MDT is Friday 12:00hrs

Incomplete forms will result in delays to the patient pathway. Referral will be accepted when all essential information is received.

Email form Save form