**MDT Referral Form**

To discuss the management of a patient with a haemoglobinopathy, please complete the form below and email it to the MDT Co-ordinator

Ralph.brown@nhs.net

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| **Patient Details** | **Consultant Details** |
| **Initials:** |  | **Referring Consultant:** |  |  |
| **DOB:** |  | **Hospital/Clinic:** |  |  |
|  |  | **Contact Number:** |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| Primary diagnosis  |  |
| Medical History |  |
| Investigation results |  |
| **Is radiology review required? ☐Y ☐N**Please state date and nature of investigation to be reviewed |  |
| Is the patient on a clinical trial? ☐Y ☐N Please provide details |  |
| Reasons for referral and question(s) to be addressed at MDT |  |
| **Final recommendation by MDT and agreed management plan** **(to be completed during the meeting)** |  |

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| Signed |  | Dr Asad Luqmani | Date: |  |