**RM Partner and South West London Cancer Alliance - Metastatic Spinal Cord Compression (MSCC) Referral Form**

**Every referral MUST have this form completed and emailed to** **sgh.mscc@stgeorges.nhs.uk**

**AND**

**0830-1630 Mon-Thu Fri 0800-1600 Bleep 6027 via SGH switchboard**

**All other times** [**www.referapatient.org**](http://www.referapatient.org) **or Bleep 7242 for urgent clinical advice only**

**All fields are mandatory.**

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| **Patient Details** | **Hospital Details** |
| Surname:  | Referring Hospital:  |
| Forename:  | Your Name:  |
| Date Of Birth:  | Your Designation:  |
| NHS Number:  | Your Email:   |
| Address:   | Bleep: Mobile:  |
| Consultant:  |
| Postcode:  | Consultant Email:  |
| Telephone:  |  |
| GP Name:  | Where is the patient currently?  |
| GP Address:   | Hospital and Ward: Contact Number:  |
| Date of admission:  |

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| **Brief and Relevant Clinical Details** |
| **Clinical History (MUST include presenting condition; motor & sensory status:**Exact date of first onset of symptoms:(dd/mm/yyyy)**Previous medical history:** **Respiratory** : Details : **Cardiac** : Details : **Other** : Details : **Performance Status: Prior to presentation:** **Current Presentation:** |
| **Oncological history:** Is patient known to have cancer? Diagnosis: If known primary specify site: If no have you contacted Acute Oncology Service? Name of Oncology consultant: Please detail their opinion: Email address for Consultant Oncologist: **Prognosis:** **Haematological:**Do you suspect Lymphoma/ Myeloma? Have you spoken to the Haematologist/AOS?  | **Oncological Treatment History:** Intent of treatment:Date last given: (dd/mm/yyyy)If Radiotherapy, to which area:  |
| **Motor Score:(Please give detailed examination)**LUL: RUL: LLL: RLL:  | **Mobility:**Date last walked: (dd/mm/yyyy)**Sensory:**Specify:  |
| **Incontinence:**Urinary: Date onset: Date Catheter inserted: Faecal: Date Onset:  | **Do they have Spinal Pain:** Specific Location: If ‘Other’ please specify: Severity (0 no pain to 10 severe pain):  |
| **Steroid Administration (Give 16mg bolus of Dexamethasone followed by 8mg BD with PPI cover):** **Other information:**  |
| **Anticoagulant/Antiplatelet Use** Specify anticoagulation drug:  |
| **Thromboprophylaxis:**  |

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| **Staging Information** | **Patient’s status** |
| MRI whole spine: Yes/No Date: (dd/mm/yyyy) Time:  | Has the patient been told their diagnosis?  |
| Other Scans?  | Do they wish to consider surgery?  |
| Outcome of Staging:  |
| MRI/CT report:  |

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| **Additional Information that may be useful to us** |
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| Please send the completed form **immediately** via e-mail to  **sgh.mscc@stgeorges.nhs.uk**If you need to discuss an emergency **Neurosurgical** referral out of office hours, please contact via www.referapatient.org or the **Neurosurgical** **registrar on call (Bleep 7242)** at St George’s Hospital **Name of Neurosurgical registrar contacted:**      **Date:**       (dd/mm/yyyy)**Time:** **Outcome:** **Please call the MSCC Coordinator to inform them of this referral – Bleep 6027 or Ext 4623** | Have **you** spoken to the **Clinical Oncologist on call** at your local Cancer Centre and pre-warned them of a potential emergency referral for radiotherapy if surgery is inappropriate?**If not**, please contact the on call Clinical Oncology SpR at either RMH or the RSCH (both via their switchboards).Please also send a copy to the Cancer Centre:**Royal Marsden Hospital** **rmh-tr.MSCC@nhs.net**  **Royal Surrey County Hospital** **rsc-tr.acuteoncology@nhs.net** |

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| **PLEASE NOTE** |
| **It is the responsibility of the referring team to ensure that ALL relevant imaging studies are made available on the SGH PACS via the IEP and that all the fields in this form are filled correctly. The two biggest sources of delay in opinions are: no available scans to ST Georges and incomplete forms. This form will be sent to the Clinical Oncologist & the AOS team.** |
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| **FEEDBACK TO BE FILLED IN BY ST GEORGES HOSPITAL ONLY:****Neurosurgical decision date & time:** Cauda Equina Compression: Spinal Cord Compression: Nerve Root Compression: Collapse: Where: **Spinal Stability:** Collar: TLSO Brace: **Mobility:**Log Roll: Bed Rest: Sit Up: Mobilise to toilet: Mobilise as Pain Permits: Any Restrictions: **Plan: If for Surgery, time frame:** **Consultant:** **Comments:** ***If you have any enquiries, please call the reviewing consultant via St George’s Hospital switchboard.*****By using this form, you agree that you or a responsible practitioner of sufficient seniority will convey this decision/MDT Outcome to your patient/next of kin and action the outcome appropriately**  |