Picture 1, PictureGI Cancer Multidisciplinary Meeting:

**Booking Form:** Palmerston North

**The expectation is the lead clinician (or a proxy) will be present to present at MDM. Please note this form acts only as a referral for MDM discussion and does not constitute a referral to a specific person, clinic, or service.** **Please complete this form electronically (not handwritten)**

**Referrals must be received before Thursday 1600 hrs.**

**Please email completed referral to:** [**MDTCo-ordinator@midcentraldhb.govt.nz**](mailto:MDTCo-ordinator@midcentraldhb.govt.nz)**Phone: 06 350 9185**

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| **Patient details:** | |  | **Referring/Responsible doctor:** | |
| **NHI:** | | DOB: | First name: |  |
| **First Name:** | | Age: | Surname: |  |
| **Surname:** | | Gender: | Specialty: | |
| Ethnicity: | |  | GP: | |
| **Referring DHB:** | |  | **Discussion type** | **Bowel Screening** |
| ​ MidCentral  Whanganui  Taranaki  Private | ​ Hawkes Bay  Wairarapa |  | ​ Initial  ​ Re-discussion | ​ Yes  ​ No |
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| **GI Cancer Location** | | |
| ​ Oesophagus  ​ Gastric  ​ Pancreas  ​ Small bowel  ​ Colon | Appendix  ​ Rectum  Anus  ​ Other | Meeting date: Click Here |
| Presenter: |

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| **Clinical details:** | | |
| **Diagnosis:** | | |
| **Current presentation:** | | |
| **Question for MDM:** | | |
| **Co-morbidities/past medical history:** | | |
| **ECOG Score**  **​​ 0** – Fully active, able to carry on all pre disease performance  **​​** **1** – Restricted in physically strenuous activity, but ambulatory and able to carry out work of light or sedentary nature  **​​ 2** – Ambulatory and capable of all self-care but unable to carry out any work activities. Ambulatory more than 50% of waking hours  **​​​ 3** - Capable of only limited self-care, confined to bed or chair more than 50% of waking hours  **​​​ 4** – Completely disabled – cannot carry on self-care. Totally confined to bed or chair  **​​** **Not known** | | |
| **Smoking/Vaping status:** | **Alcohol consumption:** | **eGFR:**  Date: Click here. Value:  **Creatinine:**  Date: Click here. Value: |
| **Previous MDM discussions:** | | |

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| **Assessments:** | | | | |
| Gastroscopy:  Yes  No  ERCP  EUS | Colonoscopy:  Yes  No  Incomplete  Sigmoidoscopy | Tumour markers:  CEA  Value:  Ca19-9  Value:  Pending | | Tumour genes:  MMR Click here.  BRAF Click here.  HER2 Click here. |
| **Pathology:** Date of surgery, location of slides, specific questions?  You will need to provide details on location of slides and reason for review | | | | |
| **Radiology:**  Private radiology:   ​​ Yes   ​​  No  What imaging/date of imaging is to be reviewed?  CT: Click here  CTC: Click here  PET: Click here  MRI: Click here | | | If yes, state which provider:  USS: Click here  IR: Click here  Other: Click here | |
| Extra comments: | | | | |

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| **Checklist** | |
| Please ensure all supporting information is emailed to [**MDTCo-ordinator@midcentraldhb.govt.nz**](mailto:MDTCo-ordinator@midcentraldhb.govt.nz)  Co-ordinating Nurse: Anna Maihi. Email: Annamai@mdhb.health.nz  Incomplete referrals will not be accepted for MDM discussion | |
| Clinic notes  Blood results (if relevant)  Histology reports | Radiology reports  Imaging sent to PACS |

**To be completed post MDM discussion**

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| **MDM outcomes:** | |
| **TNM staging:**  **Intent:** Click here.  **Pathology review:**  **Radiology review:**  **Consensus opinion:**  **Responsible clinician:** | **Referrals**  Medical oncology  Radiation oncology  Other |

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| **Quorum:** |
| **Chair of meeting:**  **Attendees:** |