MDT QR Codes / Referral Form and MDT Live List

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QR Code

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QR code found at bottom of MDT Co-Ordinator email. Links to the forms are also available on the intranet.

Link is https://forms.office.com/e/nY82Urf2RR
Or file attached

Referral Form

Portsmouth Hospitals University NHS Trust

NEW referral form for QA H&N MDT (active as of 24th June 2025)

You should receive an automated email summarising the details you've sent us, with the MDT leads and MDT coordinator copied in - that serves as confirmation of receipt of your referral.

If you don't receive it please contact us directly as your referral may not have been submitted properly - a common error is a typo in your email address (question 2).

Please do let us know if you have any constructive suggestions - o.donnelly@nhs.net

Note too that this form has been ported over from the porthosp domain and there may be glitches that we haven't resolved - it would be very helpful if you could let me know if elements aren't working, or if the question sequence isn't correct.

When you submit this form, it will not automatically collect your details like name and email address unless you provide it yourself.

* Required

1

What's your name?

Enter your answer

2

What's your email address? *

If you don't complete this accurately you won't receive a confirmation of referral and we may not receive the information at all. *If you want to copy in a colleague, so that they can see the referral has been made, add an additional email address separated by semi-colon - i.e. yourname@nhs.net; theirname@nhs.net - But please be very careful not to add any additional characters as that may prevent the system sending the information to us - if you haven't received a confirmatory email then please do not assume the referral has been received.*

Enter your answer

3

Are you referring the patient yourself, or on behalf of a consultant? *

- ○ I am the referrer
- ○ I am referring on behalf of my colleague/supervisor:

Submit

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4

Patient name: *

Enter your answer

5

Patient NHS number: *

Number must be between 999999999 ~ 9999999999

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6

What is the patient's performance status? *

ECOG	Description
0	Fully active, able to carry on all pre-disease performance without restriction.
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours.
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours.
4	Completely disabled. Cannot carry on selfcare. Totally confined to bed or chair

- PS0
- PS1
- PS2
- PS3
- PS4
- Not known

7

What is the patient's comorbidity?
Note that this is not an estimate or a count of other conditions - please score using ACE27:
https://www.rcplondon.ac.uk/file/3058/download(Note that when using ACE27 the current H&N cancer is **not** included in the scoring) *

- CM 0
- CM 1
- CM 2
- CM 3
- Not known

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What type of referral is this? *

- New patient referral, not yet known to the MDT, suspected H&N cancer.
- Patient already known to the MDT; ongoing diagnostic questions.
- Patient already known to the MDT; follow-up discussion after surgery or treatment.
- Patient previously known to the MDT; suspected recurrence.
- Referral for advice about incidental findings (e.g. PET results)
- Other

9

Site of suspected cancer: *

9

What do we need to review? (select all that apply) *

9

What treatment has the patient had most recently?

9

Referrals for incidental findings should be directed to the relevant specialty for further evaluation, rather than review in the MDT meeting. Please note below which specialty you've referred the patient to for further evaluation; if necessary we can review the case in MDT once seen by a H&N clinician.
If you feel this case needs to be discussed in the MDT prior to review by ENT or OMF then please give relevant information below: *

Enter your answer

13

What is the current question for the MDT? *

Enter your answer

14

Which MDT are you expecting to be able to discuss the case in ?

Please input date (dd/MM/yyyy)

15

Do you think the patient needs to be offered an appointment in the combined H&N clinic?(Please note this doesn't guarantee that they will be offered an appointment)

- ◯ Yes
- ◯ No

Thanks for submitting a referral - you should receive an immediate automated email confirmation - **if you don't please contact us directly** and double check that you've entered your email address correctly - typos in your email address can cause a fault in the automation meaning we won't receive the form.

MDT is Friday morning and the outcomes appear in Minestrone immediately afterwards.
Thanks again for using the form - if you've had any difficulties, discovered any glitches or would like to make suggestions please email me: o.donnelly@nhs.net

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Referral Spreadsheet

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F174 | Anabell Joel Caverly

	Id	Start time	Completion time	Email	Name	What's your name?	What's your email a	Are you referring the pa	I am referring on	Patient name:	Patient NHS num	What i	What is t	What type of refer	Site of suspe	Do you know	Do you kno
192	204	8/28/25 14:08:20	8/28/25 14:14:15	anonymous	Added	[redacted]		I am the referrer		[redacted]		PS0	CM 0	as suggetsed by reporting radiologist to discuss the lesion in mdt			
193	205	8/28/25 14:50:29	8/28/25 14:57:39	anonymous	Added			I am referring on behalf of my colleague/supervisor:	Costa			PS0	CM 1	Patient previously known to the MDT; suspected recurrence.			
194	206	8/30/25 12:18:04	8/30/25 12:28:21	anonymous				I am the referrer				PS1	CM 3	New patient referral, not yet known to the MDT, suspected H&N cancer.	Larynx		
195	207	8/30/25 13:03:36	8/30/25 13:06:37	anonymous				I am the referrer				PS1	CM 3	New patient referral, not yet known to the MDT, suspected H&N cancer.	Larynx		

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	ow	What investigat	Has the case been discussed in the	Please give a description of the case. Include	What treatn	If this is to review a post-RT	If this is to review pos	Intriguing, what didn	Referrals	Patients who	What do we ne	What is the current question	Which MDT are	Do you thi
192								mri cystic lesion reported by external radiologist and suggested mri discussion Not sure why i feel needs surgical excision for diagnosis						
193											CT	Completed CRT for T4a nT2c of Left tonsil in January 2025 - completed metabolic response on post treatment PET. Incidental 5mm left lung nodule. Repeat CT chest 24/08/25 - please can we discuss this.	9/5/2025	Yes
194				Presented with hoarse voice. heavy smoker, 60 pack year. clinically a T3 tumour. previous history of prostate cancer. has had CT and MRI and microlaryngoscpy.							CT;MRI	to discuss imaging and histology for staging and treatment	9/5/2025	Yes
195				presented with hoarse voice. heavy smoker. 60 pack year. clinically a T3 laryngeal tumour microlaryngoscopy and biopsy done							CT;MRI;Biopsy result	to discuss imaging and histology and treatment plan please	9/5/2025	Yes
196				He does have a significant cardiac history and has a hypertension bioprosthetic valve in the tricuspid position for severe tricuspid regurgitation. He also has a CRT device in situ. He has chronic renal								NO MRI due to cardiac pacemaker.		

MDT Live List

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MAXFAX	**Radiology:** SRH US 16/08/2025 SRH US 04/08/2025 SRH MRI 12/07/2025 **Histology:** SRH Histo 04/08/2025 SRH Histo 16/07/2025 **General:** Added by Anabell **MDT Comments:** "This is a 71-year-old lady presented with approximately 2 2-month history of a mass in her right parotid region. She reported that this hurts when she is lying down. An FNA performed in July 16 showed: FNA right parotid gland: consistent with an epithelial salivary gland tumour. An USS neck recommended a core biopsy of the mass, which was performed on the 4th of August with the result; Right parotid: squamous cell carcinoma, primary or a metastasis, p16 negative. A nasal endoscopy done by Mr Pratt, which didn't show any lesion. She didn't have any skin lesions on examination. She denied any other symptoms. Best treatment options such as surgery, ChemoRad, or Combination were mentioned by Mr Pratt. MRI Neck/Parotid completed 12/7/25 USS done 16/7/25. PET 22/8/25. PMH: Dad had skin cancer (unknown type). Essential	**Name:** [redacted] **Summary:** **PS: 0** **CM: 1** **Frailty Score:** **Pathology: no slides** **Radiology: MRI - 12/07/2025 - right parotid mass US guided FNA – inconclusive repeat US guided core biopsy Squamous cell carcinoma p16 negative. PET scan avid uptake right tonsil and parotid mass** **Diagnosis: Squamous cell carcinoma right Parotid** **Stage:**

Red – Not ready
Yellow – Pending
Green- Ready

MAXFAX	**Radiology:** MRI 25/08, CT 20/08, **Histology:** Histo 28/07 CH023631B/25 GILEM **General:** Tim Mellor **MDT Comments:** New patient referral, not yet known to the MDT, suspected H&N cancer. PS0 CM 1 Oral cavity Mandible (i.e. mucosa of the alveolar ridge) "Erythroleukoplakia Left mandibular alveolus (retromolar). Biopsy proven SCC(G2). Appears thin with no bone involvement on OPG but awaiting CT/MRI. No nodes clinically. Psoriatic arthritis on methotrexate. Ex-smoker." Biopsy result:MRI:CT ? for surgical rim resection mandible **Next OPA:** 05/09/2025 **To be seen by:** HNENTN 10:00	**Name:** [redacted] **Summary: Oral cancer, left mandibular alveolus** **PS: 0** **CM: 1** **Frailty Score:** **Pathology: Moderately differentiated squamous cell cancer. The biopsy shows invasive squamous cell carcinoma present 0.8mm depth** **Radiology: no soft tissue signs subtle mandibular alveolus signs – post biopsy MRI. Mandibular erosion – radiologically T4** **Diagnosis: oral Squamous cell carcinoma** **Stage: T4a N0M0** **Plan: review in clinic to discuss surgery and assess the lesion clinically.**
ENT	**Radiology:** MRI 11/07/2025 CT 02/08/2025 **Histology:** Histo 19/08/2025 CH026116M/25 O/S KIRTE **General:** Added by CR **MDT Comments:** "unilateral sore throat MRi suspicious of tongue base lesion. Nil seen on multiple examinations. panendoscopy and biopsies 19/8/25. Area looked and felt normal. for histology if malignant - treat as necessary, however if -ve ? repeat biopsies / lingual tonsillectomy / further imaging. what is the degree of suspicion from the scan CM 0 "	**Name:** [redacted] **Summary:** unilateral right sore throat MRI suspicious of tongue base lesion. Nil seen on multiple examinations. panendoscopy and biopsies 19/8/25. Area looked and felt normal. **PS:0** **CM:0** **Frailty Score:** **Pathology: Right tongue base 2**

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Feedback

It is 100% accurate and can be updated by any members of the MDT in live time.
With it being sent on the Wednesday prior to MDT, it gives all the opportunity to look and prepared in advance.
Patients can be removed from the list easily when necessary (i.e. Histology not ready).

QAH - CNS

The MDT notes have become much more structured than in the past.

Also mentioning which scans of which dates need to be discussed (on top of the info), especially when specific concern or attention needed for some imaging-related matters, helps us a lot to get the scans prepared by clearly focussed on the clinical need.

We now know better who is for St Richard and who is for us. Having St Richards patients being discussed by their radiologists, has made the burden of chasing the reports and importing the scans much less.

QAH – Radiology team

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Key Benefits

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- Provides the key data for the MDTC to add accurately to MDT.
- Saves the MDTC significant time in looking up information/deciphering the relevant information.
- Ensures clear accountability for who is adding patients to MDT.
- Allows real-time MDT prep by the clinical teams.
- Reduces email traffic – no out-of-date lists sent out – reduces patients being missed.
- Improves data completeness- e.g. Performance Status / Staging.
- Clear audit trail available – if patients are removed/bounced from MDT.