**UK National Haemoglobinopathy Panel (NHP) Virtual MDT Referral Form (return completed form to** [**gst-tr.haemoglobinpanel@nhs.net**](mailto:gst-tr.haemoglobinpanel@nhs.net)**)**

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| **Date of Referral** | 31/10/2024 | | **National MDT Date Aimed for** | | Select date via arrow |
| **Referring Clinician** | | Click here to enter text. | **Clinician’s SHT/Trust** | Click here to enter text. | |
| **Who will present this case at the NHP MDT?** | | | Click here to enter text. | | |
| **Region:** Choose your region from list  **Other (Region):** Click here to enter text. | | | **HCC  SHT  LHT** | | |
| **Patient Hospital MRN:** *(****NOT NHS number, Patient Names*** *or other sensitives identifiers. Adding initials is accepted)*  Click here to enter Hospital Number. | | | **NHP Unique Identifier:** Click here to enter text.  **(***for NHP admin only***)** | | |
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| **DISCUSSION HISTORY & PREMISE**  *Note: As per NHP referral pathway, all referrals should have previously been discussed at HCC level before referring to the NHP* | | | | | |
| **HCC Discussion Date(s)** | | | Click here to enter a date. | | |
| **HCC Discussion Summary/Recommendations** | | | Click here to enter text. | | |
| **Previous NHP Discussion?** | | | **Yes  No** | **If yes, Date:** Select date via arrow  **Previous NHP ref:** Click or tap here to enter text. | | |
| **Previous NHP Recommendation Summary** | | | Click here to enter text. | | |
| **Question to the Panel?** | | | Click here to enter text. | | |

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| **PATIENT & CASE DETAILS** | | | | | | | | | | |
| **Age at referral:** | Click here to enter text. | **Gender:** | | Click here to enter text. | | | **Diagnosis (DBA, HbSS etc.):** | | | Click here to enter text. |
| At what stage of treatment is your Patient? | | | | Diagnosis  Treatment  Psychosocial  Other | | | | | | |
| **Clinical Background** | | | Click here to enter text. | | | | | | | |
| **Presenting Issues** | | | Click here to enter text. | | | | | | | |
| **Psychosocial History** (note below):  Click here to enter text. | | | | | | | | | **Other Co-morbidities** (note below)**:**  Click here to enter text. | |
| **Current Treatment (note below):**  **Disease- modifying medication:**  Click here to enter text.  **Other Treatment:**  Click here to enter text. | | | | | | | | | **Transfusion**  Is the patient on long-term transfusion?  Yes  No  Has the patient a history of transfusion reactions and antibodies?  Yes  No  **If yes:**   1. Please state details/antibodies below:   Click or tap here to enter text.   1. Patient identifiers for **NHSBT** (for patient confidentiality, these will be deleted following NHSBT review):   **Name**: Click or tap here to enter text.  **DOB**: Click or tap to enter a date.  **NHS Number**: Click or tap here to enter text. | |
| **Genetics** *(please note exact mutations for non-Haemoglobinopathy cases)* | | | | | Click here to enter text. | | | | | |
| **Specialist/Allied Health Professional input in treatment** | | | | | | Click here to enter text. | | | | |
| **Are the patient and family aware of discussion at National MDT?**  **Yes  No** | | | | | | | | **Please provide any details of patient / family concerns regarding recommendations:**  Click here to enter text. | | |
| **Please list (below) and attach supporting documents for MDT (e.g. imaging):**  Click here to enter text. | | | | | | | | | | |

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| **MDT CATEGORIES** *(Please select as many as are relevant to help audits and data analysis)***\*** | | | |
| **Does Your referral question relate to** *(select below)***:** | | | |
| 1. Diagnosis | 2. Response assessment | 3. Psychosocial | |
| 4. Treatment - Stem cell transplant (sibling matched) | 5. Treatment - Stem cell transplant (alternative donor) | 5. Treatment – Gene Therapy | |
| 7. Treatment- Timing/Duration | 8. Treatment - Iron chelation | 9. Treatment- Other | |
| 10. Toxicity/Side-effects | 11. Treatment/trial eligibility | 12. Management - complication of blood transfusion | |
| 13. Management- Pregnancy | 14. Mortality Review | | 15. Other:  Click here to enter text. |

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| **POST-MDT DATA** (*For NHP Office*) |
| **National MDT Discussion:**  Click here to enter text. |
| **National MDT Recommendation:**  Click here to enter text. |
| **Recommendation includes referral for:**  **New therapies:** Yes  No  If yes, specify: Click here to enter text.  **Transplant/Cellular Therapy:** Yes  No  If yes, specify: Click here to enter text. |

*Many thanks for your referral. Please note:*

1. *We collect outcome data regarding your patient; please be aware that you will be contacted by email regarding this.*
2. *You will be required to present your case with accompanying slides and we ask that you send in your slides as part of the audit/accountability process for this forum.*

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| **FOLLOW UP** *( For NHP Office)***:** | | |
| **Follow-up date:** | Select date via arrow | |
| **Patient / family informed of recommendations:** | | Yes  No |
| **National MDT recommendations implemented:** | | Yes  No |
| **Reason for recommendations NOT implemented (if applicable):**   * Patient /family choice * Change in clinical condition * Other (specify): Click here to enter text. | | |
| **Patient Outcome (specify):**  Click here to enter text. | | |