**UK National Haemoglobinopathy Panel (NHP) Virtual MDT Referral Form (return completed form to** **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.
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| **Patient Outcome (specify):**Click here to enter text. |