Multidisciplinary Team Meeting (MDT) Referral and Outcome Form

Date of referral: _____ Name of referrer: _____

Date of MDT: _____ Present at MDT: _____

The patient has been informed of the purpose of the MDT referral, who may be present, what information will be discussed/shared.	**Yes** ☐		**No** ☐	
The patient has given either implied or oral consent for MDT discussion.	**Yes** ☐		**No** ☐	
The patient does not have capacity therefore consent for MDT discussion is by way of a best interest decision by the referrer.	**Yes** ☐		**No** ☐	
Specific issues patient does not want discussed at MTD				

Surname:			**Diagnosis**	
Given name:				
Address:				
			PMH	
D.O.B.	**Age**	**Gender**	**Allergies:**	
PPC:	**PPD:**		**URN No:**	**Index No:**
GSF Code *(please tick)*	**Blue (A)** ☐ *Year Plus prognosis*	**Green (B.)** ☐ *Months prognosis*	**Amber (C)** ☐ Weeks prognosis	**Red (D)** ☐ Days prognosis
Phase of illness:			**Karnofsky performance status**	
GP:	**Patient goals:**		**Keyworker and other health professionals involved in patient care:**	

Reason for referral to MDT	**Clinical details with relevant results e.g. DNACPR**

For Hospice use only

Previous MDT outcomes	**Plan of care to achieve the outcome**