**Oxford PTC TYA Psychosocial MDT Form**

(Please e-mail to [tya.oxford@nhs.net](mailto:tya.oxford@nhs.net))

**NOTE:** Please send this document back to us in **word format** (not PDF) so we can add/edit after each MDT.

In order to have a meaningful discussion about this patient at the MDT, it is **essential** to complete **all** sections of this form.

Please note: the TYA age bracket is 16 years 0 days – 24 years 364 days.

**DEMOGRAPHIC INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient name** |  | **NHS number/MRN** |  | |
| **Patient address** |  | **Date of birth**  **Age**  **Gender** |  | |
| **Patient contact details** | Phone:  Email: | **Ethnic origin** |  | |
| **GP name** |  | **GP contact details (phone)** |  | |
| **Referring hospital** |  |  |  | |
| **Name of referrer** |  | **Reason for referral (tick box)** | | |
| **Treating hospital** |  | New diagnosis  Disease recurrence  Transition  Psychological/emotional | | Other, please state: |
| **Treating consultant** |  |
| **Named**  **Key Worker** |  | **Key Worker Contact details**  **(Phone, email)** |  | |
| **Form submitted by** |  | **Date** |  | |

**DIAGNOSTIC WORK UP**

|  |  |
| --- | --- |
| **Diagnosis** |  |
| **Date of diagnosis** |  |
| **Brief clinical history**  **(presenting symptoms, diagnostic investigations & results)**  **(For designated hospitals only: Please attach last clinic letter, site specific MDT outcome, and imaging and histology reports)** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Trial available** | **Trial discussed** | **Consented** | **Reason for**  **non-participation**  **in trial** | **Trial name** |
| **Yes/No** | **Yes/No** | **Yes/No** |  |  |

|  |  |
| --- | --- |
| **Treatment plan**  **(include start date)** |  |
| **Fertility issues discussed** | **Yes/No**  (if not discussed, please give reason) |
| **Referred for fertility preservation** | **Yes/No**  (if not referred, please give reason) |
| **Date discussed at site specific MDT** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Details of family and significant others** |  | | |
| **Details of school/employment** |  | | |
| **Any other specific issues?** |  | | |
| **Complex medical needs, e.g. Autism, learning difficulties, co-morbidities, etc.** |  | | |
| **Has a Macmillan Electronic Holistic Needs Assessment (eHNA) been completed?** | Yes/No | **Is the patient happy to be referred to the Young Lives vs Cancer Team?** | Yes/No  (if yes, referral forms can be found on [this page](http://www.ouh.nhs.uk/services/referrals/cancer/tya-mdt)) |
| **Is referral to the TYA Clinical Psychologist required?** | Yes/No  (if yes, referral forms can be found on [this page](http://www.ouh.nhs.uk/services/referrals/cancer/tya-mdt)) | **19-24 year olds only:**  **Given option of place of care (Designated Hospital vs PTC)?** | Yes/No  Not applicable |
| **Designated Hospitals only:**  **Has the patient been given written information on the TYA service and team at OUH (New Patient Pack)?** | | Yes/No  (please email [tya.oxford@nhs.net](mailto:tya.oxford@nhs.net) if you do not have any New Patient Packs left) | |

**For PTC TYA MDT use only**

**MDT date:**

**OUTCOME**

|  |  |  |  |
| --- | --- | --- | --- |
| **Discussion and actions** |  | | |
| **Agreement between site specific MDT and TYA MDT** | **Yes/No** | | |
| **Young Lives vs Cancer Social Worker** | Name:  Contact details: 01865 227403 | | |
| **TYA Nurse specialist Key Worker** | Name:  Contact details: 01865 572281 | | |
| **Approved and signed by** |  | **Date** |  |

**Follow up/Review**

**MDT date:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Discussion and actions** |  | | |
| **Approved and signed by** |  | **Date** |  |