

**Greater Manchester & Oswestry Sarcoma Service**

Department of Trauma & Orthopaedics

Manchester Royal Infirmary

Oxford Road

Manchester

**Manchester Orthopaedic Tumour Service Referral Form**

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| **Incomplete forms will result in delays to the patient pathway. Referrals will be only be accepted when all essential information is received.**  **Please email completed form to:**  [**MFT.Sarcomareferrals@nhs.net**](mailto:MFT.Sarcomareferrals@nhs.net) | | |
| **REFERRING TRUST:** |  | |
| **Patient Name:** |  | |
| **Date of birth:** |  | |
| **Gender:** |  | |
| **NHS Number:** |  | |
| **Home number / Mobile number:** |  | |
| **Address:** |  | |
| **Postcode:** |  | |
| **Reason for Referral?**  **Referral for advice only Y/N** | **Suspected Bone sarcoma**  **(Refer to Oswestry**, **Tel No: 01691 404107)** | **Y/N** |
| **Suspected soft tissue sarcoma** | **Y/N** |
| **Benign soft tissue tumour** | **Y/N** |
| **Metastatic Bone disease** | **Y/N** |
|  | |
| **Any primary tumour or metastases known?**  **If yes, primary location?** |  | |
| **Has the patient had any oncology input?**  **If yes, name, contact details & location of Oncologist** |  | |
| **If currently an inpatient, please state ward and hospital:**  **Current performance status of patient:**  0: Able to carry out all normal activities without restriction  1: Restricted in strenuous activity but ambulatory and able to carry out light work  2: Ambulatory and capable of all self care but unable to carry out any work activities, up and about more than 50% of waking hours  3: Symptomatic and in bed/chair for greater than 50% of the day but not bedridden  4: Completley disabled, cannot carry out any self care, totally confined to bed/chair | | |
| **Prognosis:** | | |
| **Respect Form (DNAR) in situ: Y/ N/ N/A** | | |
| **Please confirm the Patient advised of this referral?:** | **Yes/ No** | |
| **Have you referred this patient to any other provider?:**  **If so, who?** | **Yes/No** | |
| **Confirm All Relevant Images Have been transferred via IEP**  **YES / NO** | | |

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| --- | --- | --- | --- |
| **Previous Imaging** | | | |
| **Date** (MM/YY) | **Modality** (MR/CT/XR/US/NM) | **Body Area & Laterality** | **Organisation where imaging performed** |
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| **Please provide all previous imaging reports** | | | |
| **IEP transaction number (s)** | |  | |
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|  |  |
| --- | --- |
| **Other Relevant information:** | |
| **Co-morbidities/ Past medical surgical history.** |  |
| **Anticoagulants: warfarin / clopidogrel / Other oral anticoagulant:** |  |
| **Current Medication/ Treatment:** |  |
| **Bloods: Must be provided for suspected primary bone malignant tumours and metastatic bone disease referrals.** | |
| **Hb:** |  |
| **Adj Ca++** |  |
| **Alb:** |  |
| **U+E:** |  |
| **LFT:** |  |
| **Clotting:** |  |
|  |  |
| **Reason for referral,**  **please add as much detail as possible** | |
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| --- | --- | --- |
| **Referrer information:** |  | |
| **Name of Consultant responsible for the patient:** |  | |
| **Name of Doctor completing form:**  **Job title :** | |  |
| **Contact number:** | |  |
| **Have you attached additional information along with this form? If so, please describe** | |  |

**Greater Manchester Sarcoma Referral Pathway**

**Greater Manchester & Oswestry Sarcoma Service**

**SOFT TISSUE SARCOMA**

**BONE SARCOMA**

**Any lump or swelling which is:**

 > 5cm

 Deep

 Painful

 Increasing in Size

 Recurrence after previous excision

 Has an ultrasound scan / MRI suspicious of

sarcoma

**REFER DIRECTLY TO MANCHESTER**

**ROYAL INFIRMARY**

**SARCOMA SERVICE ON A**

**SUSPECTED CANCER REFERRAL**

**(HSC 205)**

**Refer for assessment if:**

X-ray suggests the possibility of bone sarcoma

AND / OR

Unexplained bone swelling or pain in a Child / Young Person ( < 25 years)

**REFER DIRECTLY TO THE ROBERT JONES & AGNES HUNT ORTHOPAEDIC**

**HOSPITAL ON A SUSPECTED CANCER**

**REFERRAL (HSC 205)**

**Please submit referral via the E-referral Service.**

**Alternatively email or fax the referral form to :**

**Mr Amit Kumar / Mr Ashok Paul**

**Fax: 0161 276 8006**

**Email: MFT.Sarcomareferrals@nhs.net**

**Tel: 0161 276 4376**

**Please submit referral via the E-referral Service.**

**Alternatively fax the referral form to :**

**Miss Gillian Cribb / Mr Paul Cool /**

**Miss Karen Shepherd**

**Fax: 01691 404 268**

**Tel: 01691 404 107**

**For ALL other lumps NOT suspicious of cancer (including Lipomas), please refer to appropriate**

**department at local hospitals. Refer as an URGENT (NOT HSC 205) to relevant department:**

**If on a limb—Refer to Orthopaedic Department**

**If on the neck—Refer to Head & Neck Department**

**If in the groin—Refer to Haematology Department**

**If on the chest / abdomen / back—Refer to General Surgery Department**

**Please note** young people (age 16 -25 ) should be investigated or assessed very urgently i.e. within 48 hours

**Any lump or swelling > 5cm which is:**

 > 5cm

 Deep

 Painful

 Increasing in Size

 Recurrence after previous excision

 Has an ultrasound scan / MRI suspicious of

sarcoma

**DAY 0—7**

**DAY 7—10**

**DAY 10—14**

**Quality Criteria**  
Dedicated patient

Tracker monitors time

On pathway  
  
**Standard 1:**  
All patients with

Suspected Sarcoma

are discussed at the

Sarcoma MDT  
  
  
**Standard 2:**   
All patients are

Assessed by a

Sarcoma Specialist  
  
  
**Standard 3:**   
All sarcoma patients

Are introduced to

Their Clinical Nurse

Specialist

**Standard 4:**  
Patients will be

Considered for a

Clinical trial if

Applicable

**Refer directly to MFT Sarcoma Service**

**Case reviewed in either an Outpatient**

**Appointment and/or a Multi-disciplinary Team meeting (MDT)**

**If confirmed Sarcoma diagnosis a**

**Management plan will be created and**

**confirmed at GMOSS MDT**

**DAY 15—62**

**You will received your first definitive**

**Treatment detailed in the Management plan.**

**Greater Manchester Soft Tissue Sarcoma Patient Pathway**

**Greater Manchester & Oswestry Sarcoma Service**

**Greater Manchester Metastatic Bone Disease Referral Pathway Greater Manchester & Oswestry Sarcoma Service**

**BONE METASTASES**

**Refer for assessment if:**

Imaging (XR, CT, MRI) suggests the possibility of bone metastases

AND / OR

Fracture

Non Weight Bearing

Pain

Limb or joint swelling

Email or Fax referral form to:

Mr Amit Kumar

Fax: 0161 276 8006 (Tel: 0161 276 4376 to confirm receipt)

Email: [MFT.Sarcomareferrals@nhs.net](mailto:MFT.Sarcomareferrals@nhs.net)

OR

Your local Orthopaedic Department Metastatic Bone Disease Lead

**For any bone lesion with no previous history of cancer, please refer on bone sarcoma pathway**

**This is not a referral pathway for patients with Cancer of Unknown Primary – please refer to CUP team**

**Please note** young people (age 16 -25 ) should be investigated or assessed very urgently i.e. within 48 hours