**Vascular Anomalies MDM Referral Form**

Please send to:

**Gst-tr.****VascularanomaliesGSTT@nhs.net**

|  |  |
| --- | --- |
| **Patient Name:**  | **Hospital Number:** |
| **DOB:**  | **NHS Number:** |
| **Referring consultant:**  | **Referring Hospital:** |
| **Contact e-mail:**  | **Admin Contact:**  |
| **Clinical details:** |
| **Previous treatments:** |
| **Questions for MDM:** |
| Is referral for - Treatment ⃝ MDT discussion only ⃝ |

**Investigations included with referral**

Medical photographs ⃝

Sent via email with this form/Available on WabaMML (delete as appropriate)

Imaging (please include reports) ⃝

Ultrasound/MRI/Fluoroscopy/CT (delete as appropriate)

Date of images:

Image linked via the Image Exchange Portal/Available on GSTT/KCH/Lewisham/DGT PACS

Others (eg histology) ⃝

Please provide details: