**Vascular Anomalies MDM Referral Form**

Please send to:

**Gst-tr.**[**VascularanomaliesGSTT@nhs.net**](mailto: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: