**Pituitary MDT Referral Form**

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| **Date of Referral:** |  |

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| **PATIENT DETAILS** | **DETAILS OF REFERRING CLINICAN** |
| **NAME:** |  | **NAME:** |  |
| **ADDRESS:** |  | **HOSPITAL:** |  |
| **CHI NUMBER:** |  | **CONTACT DETAILS:** |  |

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| **PRESENTING COMPLAINT**(include current symptoms) | **PAST MEDICAL HISTORY**(please include comorbidities and any previous treatment) |
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| **RELEVANT MEDICATION**(Please include anticoagulants, steroids, anticonvulsants) | **IMAGING FOR REVIEW**(Please include date/place of imaging) |
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| **BIOCHEMISTRY FOR REVIEW**(Include if available - Cortisol, short synACTHen, T4, TSH, Prolactin, Testosterone, IGF-1) | **OTHER TESTS FOR REVIEW**( Please include any dynamic tests e.g. for Cushing disease) |
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| **REVIEWED BY ENDOCRINOLOGIST?**(Please state where and who.) | **REVIEWED BY OPHTHALMOLOGY? VISUAL FIELD ASSESSMENT?** |
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| **QUESTION TO BE ANSWERED BY THE MDT** |
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**The Pituitary MDT is acting in an advisory role and its recommendations are based to a significant degree on the information provided on this form. The completed referral form should be emailed to the MDM Co-ordinator:** **Stuart.Ritchie@nhslothian.scot.nhs.uk**

**Pituitary Post- MDT Outcome**

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| **Date Discussed:** |  |

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| **OUTCOME OF THE MDT** |  |
| **PERSON TO ACTION POINTS FROM THE MDT** |  |
| **COPIES OF THE LETTERS TO BE SENT TO** |  |