MSCC referral form

Referrals will be received through the Royal National Orthopaedic Hospital (RNOH) website. Referrals will only be accepted via the electronic version of the referral form.

The referral form will request patient and clinical details and will include a request for imaging to be transferred via IEP. If for any reason it is not possible to share the imaging in this way, this must be discussed with the MSCC co-ordinator, and alternative instructions for viewing imaging provided on the referral form. Once the details are complete the referral should be sent to the RNOH by selecting the submit button.

The referrer will receive an automated reply acknowledging receipt of the referral.

During normal working hours (9.00am - 5.00pm) the referrer will be contacted by the MSCC co-ordinator and further information will be provided at that point.

Out of hours, instructions on how to proceed will be included in the automated acknowledgement of receipt of the referral.

The communication plan for these referrals will be as follows:

- The referral will be acknowledged upon receipt.
- The RNOH aims to provide an opinion within 2 hours providing all information is available, or to a timescale given by the MSCC co-ordinator.
- Confirmation of the treatment plan will be issued to the referrer within 2 working days of the referral.
- Updates, e.g. outcome from outpatient appointment, will be provided within 2 working days of that event.

These forms are only for tertiary referrals from other hospitals. We will not accept referrals from GPs using the online referral form below.

If you are a GP referring to the RNOH please use the NHS e-referral system, e-RS.

Please confirm that you are a Hospital doctor: *
I am a Hospital doctor

Referrer’s details:

Referrals will only be accepted from consultants in oncology, neurosurgery or orthopaedics

Referring consultant’s name: *

Referring consultant’s department: *

Referrer’s hospital/surgery address: *

Referrer’s telephone number: *

Referrer’s mobile telephone number: *

Referrer’s email: *

Patient details:

Patient’s First Name: *

Patient’s Surname: *

Patient’s address: *
Patient’s GP name and address: *

Patient’s DOB: *
Year
Month
Day

Patient’s tel:

Patient’s NHS no:

Clinical history:

Co-morbidities:
Tumour staging:

Neurology:
Neurology: Y/N: *

☐ Yes
☐ No

If yes, detail:

Steroids given:
Steroids given Y/N: *

☐ Yes
☐ No

If yes, dose:

Histopathology Diagnosis:
Histopathology Diagnosis: Y/N: *
☐ Yes
☐ No
If yes, what type:

Chemotherapy/Systemic therapy:
Chemotherapy/Systemic therapy: Y/N: *
☐ Yes
☐ No
If yes, detail:

Radiotherapy:
Radiotherapy: Y/N: *
☐ Yes
☐ No
If yes, detail:

Bloods results:
Date:
WBC:
Neu:
Plts:
Hb: 

Clotting screen: 

PT: 

APTT: 

Fibrinogen: 

Routine biochemistry (RF, LFT, bone profile): 

Available imaging:

Please tick box

Available imaging:

☐ XRs

☐ MRI

☐ CT

☐ PET-CT

All images have to be uploaded to IEP before referral can be accepted

IEP available: 

☐ Yes

☐ No

IEP details:
Area(s) of pain:

Spinal stability:

Consent to record telephone conversation with RNOH consultant

Please note that any clinical telephone conversation between referrer and consultant will be recorded and a transcription of that conversation will be entered as part of the patient record.

Please tick this box to confirm you consent to this: *

☐ Yes