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**PAEDIATRIC HAEMATOLOGY / ONCOLOGY**

**INTER-PROVIDER TRANSFER/MINIMUM DATASET PROCESS**

In line with the national cancer waiting times standard for children with a suspected or confirmed diagnosis of cancer, patients should receive treatment within 31 days of referral or consultant upgrade.

It is essential that Paediatric Oncology Shared Care Units (POSCUs) provide all required patient details on the below form when referring to GOSH, to enable the appropriate clinical triage of referrals and the accurate reporting of the patient’s pathway milestones.

* **Please fax a completed minimum dataset form for any clinically urgent inpatient referral to Lion/Elephant/Giraffe ward on 0207 813 8265.**
* **Please fax a completed minimum dataset form for any outpatient or second opinion referral to 0207 813 8410 (Haematology) or 0207 813 8588 (Oncology).**
* **Please provide an accompanying referral letter detailing the patient’s family history, medical history and current medications.**

GOSH will adopt the following process for managing inter-provider transfers when the referring trust fails to provide the attached Haematology/Oncology minimum dataset referral form, as outlined below:

1. GOSH will contact the referring trust within 1 working day of urgent inpatient admission OR receipt of consultant referral and request the attached form within 2 working days.
2. If that approach does not elicit the information requested, the GOSH MDT Co-ordinator will contact the referring trust for a second time advising them that the referring trust has a further 2 working days from the date of the second contact to provide the information.
3. If that approach does not elicit the information requested, the GOSH Service Manager will contact the referring trust for a third time advising them that the referring trust has a further 2 working days from the date of the third contact to provide the information.
4. If the information is still not provided after the third approach, the GOSH Chief Operating Officer will contact the Chief Operating Officer of the referring trust directly via email, requesting the information within 24 hours.
5. If this does not elicit a response, the patient’s pathway will be reported with blank fields for ‘decision to refer date’ and ‘cancer referral to treatment start date’, in relation to any Open Exeter submissions.

**INTER-PROVIDER TRANSFER/MINIMUM DATASET FORM**

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| --- | --- | --- | --- |
| **Patient details** | | | |
| Patient forename |  | Patient surname |  |
| NHS number |  | Date of birth |  |
| Address and post code |  | | |
| Gender | M / F | Ethnicity |  |
| Name of/relationship to main carer |  | Main carer mobile and home number |  |
| Patient GP name, address and post code |  | | |
| Confirmed as eligible for NHS treatment? | Yes / No | Interpreter required? Specify language | Yes / No |

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| --- | --- | --- | --- | --- | --- |
| **Referral details** | | | | | |
| Date referral sent to GOSH |  | Name/specialty of referring consultant |  | | |
| Trust provider code |  | Trust name |  | | |
| MDT Coordinator name |  | | MDT Coordinator email/phone |  | |
| Referral priority type (circle): | | Two week wait GP referral | Urgent | Routine | Consultant/ MDT second opinion |
| EITHER Date GP referred to Trust |  | AND  Date GP referral received by Trust |  | OR  Date of consultant upgrade at Trust |  |
| Date patient first seen at Trust |  | GP referral to first seen reason delay | (applicable if over 14 days only) | | |

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| --- | --- | --- | --- |
| **Diagnosis and investigation details (where known)** | | | |
| Patient diagnosis |  | | |
| Diagnosis ICD-10 code |  | Date diagnosis confirmed |  |
| Has the patient undergone imaging? | Yes / No  If Yes, please send scans via IEP to the relevant GOSH consultant | Does the referring Trust hold pathology specimens? | Yes / No  If Yes, GOSH will  contact the Histopathology department direct |