**Patient Details**

**Clatterbridge Road, Bebington, Wirral CH63 4JY**

**Enquiries: 0151 556 5383**

Surname: Click here to enter text.

Forename: Click here to enter text.

Date of Birth: Click here to enter a date.

NHS Number: Click here to enter text.

Is patient known to Clatterbridge? Yes  No

If Yes - CCC Number: Click here to enter text.

Site of Primary Cancer: Click here to enter text.

Patient location: Home  OR Enter Location / Ward here.

**Referral Details**

Referral discussed with Oncology / Haematology Consultant? Yes  No  If Yes: Enter consultant name.

Has an MDT referral been completed? Yes  No  If Yes, date scheduled: Click here to enter a date.

Please enter details of patient presentation: Symptoms and symptom duration, specific site(s) of pain (please note: ‘Back pain’ is not specific enough). Attach any additional information (scan reports or MDT reports etc.) with this completed referral.

Please give details of the referral below:

**Additional Imaging Studies:** Additional diagnostic imaging scheduled? Yes  No

If yes, please state type: Click here to enter text.

Date imaging planned: Click here to enter a date.

**Eligibility Criteria** (Patient should meet all criteria, however may still be accepted following direct discussion)

Known malignancy

Life expectancy of at least 3 months

Able to lie flat and fairly still for up to 20 minutes

Patient aware and in agreement for radiotherapy

Pain adequately controlled to allow safe transfer

**Eligibility Criteria Dependent on Requested Treatment site**

**Bone**

**Whole Brain**

**Soft Tissue / Nodal Masses**

Radiologically confirmed bone metastasis corresponding to pain

No impending fracture (cortical involvement of >50%) or planned surgical fixation of bone

No more than 3 painful sites

Eligibility criteria for Surgery OR SRS input have not been met

Performance status <3

Patient is under the care of or has been referred to appropriate CCC Oncologist / Haematologist

Eligibility criteria for Surgery OR radical / high dose palliative radiotherapy has not been met

**Surgical / Orthopaedic Discussion** (Only required if referral for treatment includes a weight bearing joint)

Has a surgical / orthopaedic referral been considered? Yes  No  (include details within referral above)

**Follow-up** (Provide details of any follow-up with team planned after radiotherapy treatment)

Consultant Name: Click here to enter text.

Follow-up in (weeks): Click here to enter text.

Hospital / Hospice Site: Click here to enter text.

If no follow-up planned / required, please tick:

**Referrer Details**

Name: Click here to enter text.

Role: Click here to enter text.

Contact: Click here to enter text.

**ALL referrals must be received via the Palliative Clinic e-mail address:** [ccf-tr.Palliativepatientreferral@nhs.net](mailto:ccf-tr.Palliativepatientreferral@nhs.net)