

Radiotherapy referral form for Benign Disease

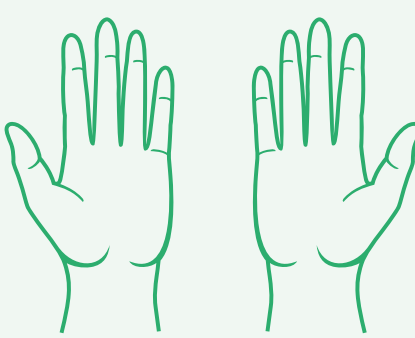
Please email to benign@genesiscare.co.uk

Patient Details

First name		Mobile
Surname		Email
Address		Self-pay <input type="radio"/> Insured <input type="radio"/>
Postcode		Insurers name
Date of birth	Male <input type="radio"/> Female <input type="radio"/>	Policy number
Tel		


Referral information Please complete all relevant fields

Dupuytren's disease

Investigations, dates & results
Previous treatments received and results (with dates)
Reasons for referral (please tick) 1. Early progressive disease <input type="radio"/> a. Early i.e. no contracture or minimal contracture b. Progression in last 12 months e.g. increasing nodules/cords, increased symptoms, increased tightness 2. Post-surgical release (date and method) <input type="radio"/> 3. Other (please specify) <input type="radio"/>
Extent of disease: Please either provide an annotated photo with orientation, or mark-up the diagram below: 

Referral information Please complete all relevant fields

Ledderhose disease

Investigations, dates & results
Previous treatments received and results (with dates)
Reasons for referral (please tick) a. Pain <input type="radio"/> b. Increasing size of nodules <input type="radio"/> c. Difficulty in walking or standing <input type="radio"/>
Extent of disease: Please either provide an annotated photo with orientation, or mark-up the diagram below: 

Referral information Please complete all relevant fields

Heel pain (Plantar Fasciitis and Achilles Tendonitis)

Date of onset of pain	
Investigations + results	
Past treatment, including conservative treatment, shockwave therapy, radiotherapy, injections, surgery (with dates)	
<p>Sites of tenderness</p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> L R </div>	<p>Sites of tenderness</p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> L R </div>

Referring Consultant Details

First name	Patient treatment briefing completed in accordance with GCCUK guidelines <input type="radio"/>
Surname	
Address	Patient has been briefed on post-treatment PROMS process <input type="radio"/> Please specify how you would like to receive the clinical report: Email <input type="radio"/> Post <input type="radio"/> Fax <input type="radio"/>
Postcode	By signing, you have understood and are authorising GenesisCare to contact the patient regarding radiotherapy treatment. Signature _____ Date _____
Tel	
Fax	
Email	