Radiotherapy referral form for Benign Disease

Patient Details

First name		Mobile
Surname		Email
Address		Self-pay ○ Insured ○
Postcode		Insurers name
Date of birth	Male ○ Female ○	Policy number
Tel		

Referral information Please complete all relevant fields

Dupuytren's disease

Investigations, dates & results

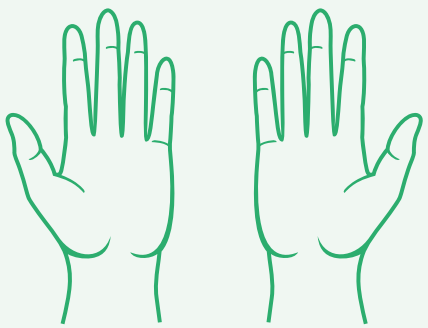
Previous treatments received and results (with dates)

Reasons for referral (please tick)

1. Early progressive disease ○
   - 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) ○
3. Other (please specify) ○

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

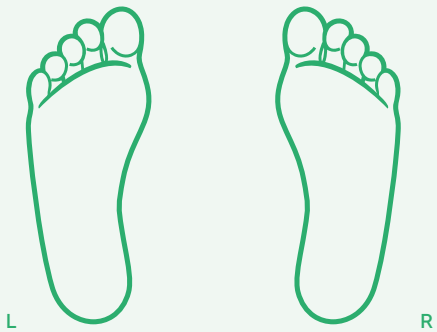
Previous treatments received and results (with dates)

Reasons for referral (please tick)

- a. Pain ○
- b. Increasing size of nodules ○
- c. Difficulty in walking or standing ○

Extent of disease:

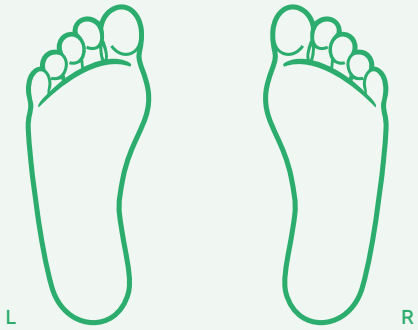
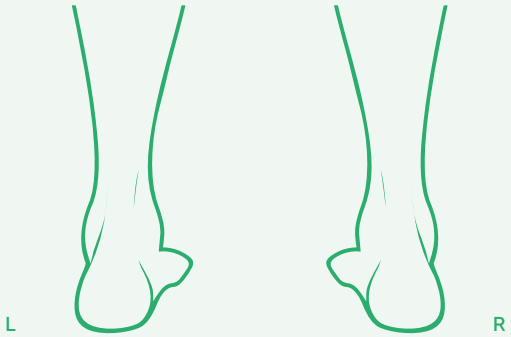
Please either provide an annotated photo with orientation, or mark-up the diagram below:



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)

Sites of tenderness  	Sites of tenderness 

Referring Consultant Details

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