

COLORECTAL MDT Referral Proforma – **PERITONEAL**

Patient Name:	UHB/NHS Number:	D.O.B:
Patient Address:	Patient Tel No:	GP:
Referring Hospital:	Referring Consultant:	CNS:
Referrer Email:	Referrer phone number:	
Referral to UHB Consultant: No Yes	Name:	
CWT TARGET DATE:	2WW UPGRADE	

Clinical Details: (Include prior treatment [Previous Surgery/Relevant Chemotherapy], radiology, and histology):	
Performance Status:	BMI:
Significant Comorbidities:	
Question for MDT:	
Is referral for treatment:	or MDT discussion only:

DIAGNOSIS:	DATE:
HISTOLOGY:	Location: Date:
LAST COLONOSCOPY:	Location: Date:
PREVIOUS RESECTION:	Location: Date:
CT SCAN:	Location: Date:
PET-CT:	Location: Date:
MRI Liver:	Location: Date:
Ensure all histology slides/reports and imaging films/reports from the time of diagnosis are sent with the referral.	
Date Patient agreed to transfer to UHB:	
Send completed referral form to UHB-tr.CancerTertiaries@NHS.net	
<u>Please note cut off time for inclusion in MDT is Wednesday 12:00hrs</u>	

Incomplete forms will result in delays to the patient pathway. Referral will be accepted when all essential information is received.