Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

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 HGSColorectalMDTRequest@uhb.nhs.uk

Please note cut off time for inclusion in MDT is Wednesday 12:00hrs

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

Email form Save form