



The Colorectal and Peritoneal Oncology Centre

Advanced Pelvic Cancer Service

Expedited referral form

Please use this form to refer patients who have persistent T4 disease / threatened CRM / extra-mesorectal pelvic lymph nodes AND who have completed neoadjuvant treatment

Expedited referrals received by 5pm on Monday will be discussed in the MDT the following Monday, with the outcome returned to the referring hospital the same day.

Please complete **ALL FIELDS** and then send this form and accompanying results and reports by e-mail to the-christie.cpocreferrals@nhs.net

We are happy to speak to referring consultants should they wish to discuss the scare before a formal referral is made. This can be done by speaking to The Christie colorectal consultant on-call that day who is contactable via switchboard (0161 4463000)

Checklist- please check all items before sending
If information is missing from this form your referral may be delayed

- | | |
|---|--------------------------|
| All fields on the form are complete | <input type="checkbox"/> |
| CT thorax abdomen and pelvis within 5 weeks of referral | <input type="checkbox"/> |
| MRI pelvis within 5 weeks of referral | <input type="checkbox"/> |
| All endoscopy, operation and histology reports are included with referral | <input type="checkbox"/> |
| The patient has been/will be informed of this referral | <input type="checkbox"/> |

REFERRAL FOR ATTENTION OF: CONSULTANT OF THE WEEK

PATIENT INFORMATION

Date patient informed/to be informed of referral to The Christie: Click or tap here to enter text.

Patient Name: Click or tap here to enter text.

Patient's address: Click or tap here to enter text.

Date of birth: Click or tap here to enter text.

NHS number: Click or tap here to enter text.

Referring hospital: Click or tap here to enter text.

Referring consultant: Click or tap here to enter text.

Secretary phone number: Click or tap here to enter text.

Secretary e-mail: Click or tap here to enter text.

Name of clinician completing form: Click or tap here to enter text.

Role of clinician completing form: Click or tap here to enter text.

Named local colorectal surgeon Click or tap here to enter text.

Named local oncologist Click or tap here to enter text.

Local CNS name: Click or tap here to enter text.

Local CNS phone number: Click or tap here to enter text.

CLINICAL INFORMATION

Reason for referral: Click or tap here to enter text.

Question for Advanced Pelvic Cancer MDT: Click or tap here to enter text.

Clinical details including previous surgery: Click or tap here to enter text.

Site of tumour: Click or tap here to enter text.

Pre-treatment TNM stage: Click or tap here to enter text.

Histological diagnosis (please include report): Click or tap here to enter text.

Mismatch repair status: Choose an item.

Endoscopy date (please include report): Click or tap here to enter text.

EUA date (if done, please include report): Click or tap here to enter text.

CT and MRI scan dates (please list all and include reports): Click or tap here to enter text.

Any other imaging (please list with all with dates and include reports): Click or tap here to enter text.

Local MDT discussion dates (please list all and include outcomes): Click or tap here to enter text.

Neoadjuvant treatment received: Click or tap here to enter text.

Date neoadjuvant treatment completed: Click or tap here to enter text.

Performance status: Choose an item.

Past medical history/co-morbidities: Click or tap here to enter text.

Patient impact statement: Click or tap here to enter text.