Building healthier lives

NHS
University Hospitals Birmingham
NHS Foundation Trust

COLORECTAL MDT Referral Proforma –
EARLY RECTAL CANCER/ADVANCED RECTAL POLYP

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, radiology, histology and PMH, current medication):

Performance Status: BMI:

Significant Comorbidities:

Question for MDT:

Is referral for treatment: ◯ or MDT discussion only: ◯

DIAGNOSIS:	DATE:	
COLON/FLEXISIGMOIDOSCOPY:	Location:	Date:
HISTOLOGY:	Location:	Date:
CT SCAN TAP:	Location:	Date:
MRI RECTUM:	Location:	Date:

Ensure all histology slides/reports and imaging films/reports are sent with the referral.

Date Patient agreed to transfer to UHB:

Send completed referral form to UHB-tr.CancerTertiaries@NHS.net

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