**Request for discussion at Salisbury Colorectal MDT**

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| PATIENT DETAILS (Or use Patient Label)Patient Name:Hospital No:NHS Number:Named Consultant: | Requested By: Position: Bleep/Tel: Date: |

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| **All fields of this referral form must be completed prior to discussion.****Please be advised that this is a request for DISCUSSION ONLY.****If further tests are recommended by the CRC MDT, then it is expected that the referring team will action these and communicate with the patient.** |
| **Question for the MDT?** |
| **Presenting Symptoms:**CIBH: YES/NO Rectal Bleeding: YES/NOAbdominal Mass: YES/NO Weight loss: YES/NOEmergency admission: YES/NO Obstructive symptoms: YES/NO |
| **Past Medical History/Co Morbidities**: (Inc. fitness for treatment/surgery)  |  |  |  |
| **Performance Status:** (Please specify): 0 - Able to carry out all normal activity without restriction1 - Restricted in strenuous activity but ambulatory and able to carry out light work2 - Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours3 - Symptomatic and in a chair or in bed for greater than 50% of the day but not bedridden4 - Completely disabled; cannot carry out any self-care; totally confined to bed or chair |  |  |  |

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| **Investigations and results:**Tumour Markers (CEA):CT: MRI:Colonoscopy/Flexi Sig:  | USS:PET – date:Other (Please Specify) – date:  |
| **Working diagnosis:****Provisional staging: T N M** |
| **Patient understanding of situation/diagnosis:** |
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| **Additional information:**  |
| **MDT comments:** |