**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/NO  Abdominal Mass: YES/NO Weight loss: YES/NO  Emergency 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 restriction  1 - Restricted in strenuous activity but ambulatory and able to carry out light work  2 - Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours  3 - Symptomatic and in a chair or in bed for greater than 50% of the day but not bedridden  4 - 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:** | |
| **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.** | |
| **Additional information:** | |
| **MDT comments:** | |