St Mark's Hospital
Complex Cancer Clinic

Putting patients at the HEART of everything we do

NHS
London North West University Healthcare
NHS Trust

REFERRAL CHECKLIST

DATE OF REFERRAL	**REFERRING HOSPITAL**	**CLINICIAN CONTACT DETAILS**
REFERRING CLINICIAN	**OTHER KEY CLINICIAN/ CNS**	**PATIENT CONTACT DETAILS**
PATIENT NAME	**DATE OF BIRTH**	
NHS NUMBER	**HOME ADDRESS**	

INDICATION FOR REFERRAL

Locally advanced primary rectal cancer (PR-bTME)	☐
Recurrent rectal cancer	☐
Recurrent anal cancer	☐
Locally advanced/ recurrent colon cancer	☐
Colorectal peritoneal metastases	☐
Other tumours	☐

DIAGNOSIS

TNM staging (indicate definite/ probable metastases)	

RADIOLOGIC IMAGING

	YES	DATE	REPORT	NO
CT CAP pre-treatment				
MRI pelvis pre-treatment				
CT CAP ≤ 6 weeks of referral				
MRI pelvis ≤ 6 weeks of referral				
PET CT (if performed)				
MRI liver (if performed)				

HISTOLOGY

	YES	NO
Original histology report		
If recurrent: histological proof		

PATIENT FUNCTIONAL STATUS

1		2		3		4		5	

ONCOLOGICAL/ SURGICAL HISTORY

DATE	MODALITY/ TYPE/ SURGERY	NOTES

CLINICAL DETAILS AND QUESTION FOR CCC MDT

PLEASE EMAIL FORM TO:

lnwh-tr.cccreferrals@nhs.net