REFRESH

Illawarra Shoalhaven Colorectal MDT Referral Form

SUBMIT

PATIENT DETAILS

SURNAME: _____ FIRST NAME: _____ SEX M ◯ F ◯

ISLHD MRN: _____ DOB: _____ GP: _____

REFERRER

SURGEON ☐ SPECIALIST ☐ MEDICAL ONCOLOGIST ☐ RADIATION ONCOLOGIST ☐

NAME: _____

1ST DATE REFERRED TO SPECIALIST _____ 1ST CONSULTATION DATE _____

TRIAGE CATEGORY

1. For priority discussion		2. For Discussion		3. Not for Discussion	
1Ai New rectal Ca prior to Rx	◯	2Ai New Stage II/III/IV CRC	◯	Stage I colon	◯
1Aii New anal Ca prior to Rx	◯	2Aii New pt no diagnosis	◯	Stage II colon	◯
1Aiii New CRC Complex Stage IV	◯	2Bi Pt previously treated	◯	3B Data only	◯
1B Re-discussion Complex Stage IV	◯	2Bii Pt currently treated	◯		

WORK-UP

PRESENTATION: Screening/FOBT ◯ Symptomatic ◯ Surveillance ◯

SYMPTOMS: PR bleeding ☐ Nausea/Vomiting ☐ Abdo mass ☐

Bowel obstruction ☐ Abdo Pain ☐ Jaundice ☐ CEA rising ☐

PS (ECOG): **Select ECOG**

IMAGING

	RADIOLOGY PROVIDER	DATE	TYPE
1.	Select an item		Select an item
2.	Select an item		Select an item
3.	Select an item		Select an item

SURGERY/PATHOLOGY

	PROCEDURE	DATE	PATHOLOGY PROVIDER	EPISODE NO.
1.	Select an item		Select an item	
2.	Select an item		Select an item	
3.				

CLINICAL QUESTION

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