***ATTACH PATIENT LABEL HERE***

Given Name(s) ………………………………………

Surname …………………………………………….

Date of Birth …………………………………………



**Liver Transplant for Colorectal Liver Metastasis Referral Requirements**

**Referral Form**

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| **In addition to the form below, please also include referral letter (with patient contact details)** (Check box to confirm attached)Please fully complete **all sections** of this form. Please attach all required supporting documents (imaging reports, pathology, MDM discussions) and fax/email to the address below. Incomplete referrals will not be accepted and assessment regarding suitability for transplantation will not proceed until all relevant information is received. |
| ***Primary Tumour:****Please provide all baseline imaging and complete below:*¨ Initial Diagnosis Imaging Date/s: \_\_\_\_\_\_\_ Where were images done? \_\_\_\_\_\_\_\_\_\_\_\_¨ Date and type of colorectal operation \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_¨ Histology Report ¨ Genomics Report (BRAF mutated excluded)¨ Neoadjuvant chemoradiation Treatment \_\_\_\_\_\_\_\_\_\_\_\_ Date started/finished: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_¨ No preoperative treatment  |
| ***Metastatic Liver Disease*** ¨ Synchronous ¨ Metachronous¨ Initial Diagnosis Imaging ¨ CT ¨ MRI ¨ PET Scan  Date/s: \_\_\_\_\_\_\_ Where were images done? \_\_\_\_\_\_\_\_\_\_\_\_¨ Treatment History Treatment (1st line) \_\_\_\_\_\_\_\_\_\_\_\_ Date/s: \_\_\_\_\_\_\_ Treatment (2nd line) \_\_\_\_\_\_\_\_\_\_\_\_ Date/s: \_\_\_\_\_\_  Treatment (3rd line) \_\_\_\_\_\_\_\_\_\_\_\_ Date/s: \_\_\_\_\_\_ ¨ Liver resection  ¨No ¨Yes ¨Type & date: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ /\_\_\_\_\_\_/\_\_\_\_\_ ¨ Histology Report ¨ Stable disease after treatment¨ Partial Response(Note response to chemotherapy must be observed for at least 6 months)(Note time between diagnosis of liver mets and referral must be at least 1 year)¨ Copy of previous MDM stating patient not suitable for resection |
| ***Referral Requirements:***¨ Colonoscopy (within 3 months)¨ MRI primovist Liver (within 6 weeks) Date: \_\_\_\_\_\_\_\_ Where were images done? \_\_\_\_\_\_\_\_\_\_\_\_¨ CT CAP/Liver (within 6 weeks) Date: \_\_\_\_\_\_\_\_ Where were images done? \_\_\_\_\_\_\_\_\_\_\_\_¨WB-PET Scan (within 3 months) Date: \_\_\_\_\_\_\_\_ Where were images done? \_\_\_\_\_\_\_\_\_\_\_¨ Referring Unit most recent MDM outcomes |
| **Please send to:****Fax: transplantoncology@austin.org.au**  |