***ATTACH PATIENT LABEL HERE***

Given Name(s) ………………………………………

Surname …………………………………………….

Date of Birth …………………………………………



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

**Referral Form**

|  |
| --- |
| **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** |