****

**Referral form for HCC MDM Discussion**

The sections marked with an asterisk (\*) MUST be completed. Scans and biochemistry results must be dated within four and two weeks, respectively. Incomplete forms and missing data will lead to delays in treatment decision.

Completed forms need to be emailed to **kch-tr.hpbreferrals@nhs.net**

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT DETAILS** | | | |
| Patient's Surname\* |  | Patient's Forename\* |  |
| Gender\* |  | |  |  | | --- | --- | | Date of Birth\* |  | | NHS ID Number\* |  | | |
| Home Address\* |  | Home Telephone No |  |
| Postcode\* |  | Mobile Telephone No\* |  |
| Patients GP Adrress\* |  | GP Telephone No. |  |
| PostCode\* |  | Name of Patients GP |  |
| Is Patient aware of Diagnosis?\* |  | Is patient aware of referral to KCH?\* |  |
| Will the Patient Require an Interpreter?\* | If yes, which language? | Will patient require transport?\* |  |

|  |  |  |
| --- | --- | --- |
| **REFERRING ORGANISATION** | | |
| Referring Clinician and Speciality\* |  | |
| Referring Organisation Name\* |  | |
| Referring Organisation Hospital Number\* |  | |
| Name of Person Completing Proforma\* |  | |  |  | | --- | --- | | Contact No. |  | | Contact Email |  | |
| Full name of local CNS\* |  | |  |  | | --- | --- | | Contact No.\* |  | | Contact Email\* |  | |

|  |  |  |
| --- | --- | --- |
| **REASON FOR REFERRAL\***  **(Please only select one of the following three options)** | | |
| MDM Opinion Only  O | For MDM discussion and possible treatment  O | Other  O |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CLINICAL INFORMATION\*** | | | | |
| Performance Status (0-4) |  | | | |
| Tumour Presentation | O Screen Detected O Liver Decomposition  O Incidental O Rupture | | | |
| Clinical Symptoms | Systematic Symptoms:  Pain O  Weight Loss O | Relevant Past Medical/Surgical History | Diabetes  Cholesterol  Hypertension  Ischaemic Heart Disease  Chronic Kidney Disease  Cancer | |  | | --- | |  | |  | |  | |  | |  | |  | |
| Prior History of Liver Disease | |  |  | | --- | --- | | Aetiology: | | | HBV  HCV  Alcohol  Type 2 Diabetes  Cirrhotic  Decompensation  Other: | |  | | --- | |  | |  | |  | |  | |  | |  | |  | | | Evidence of Decompensated Liver Disease | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Jaundice  Encephalopathy  Ascites  Bleeding Varices | |  | | --- | |  | |  | |  | |  | | |  | | | |

|  |  |
| --- | --- |
| ***Investigations ie. CT, MRI etc*** | ***Report*** |

|  |  |
| --- | --- |
| Full Renal Function | **eGFR:** **Creatinine:** **Urea:** |
| Tumour Markers\* | **AFP**: **CA19-9**: |
| Liver Function Tests\* | **Albumin**: **Bilirubin**: **INR**: **Platelets**: **ALT/AST**: **ALP**: |

|  |  |
| --- | --- |
| **CLOSING REMARKS** | |
| Further Comments (If Any) |  |
| Patient concerns (If Any) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **CANCER PATHWAY DETAILS** | | | |
| 2WW pathway clock start date (If applicable) |  | 62 Day Breach Date |  |
| Date First Seen |  | Adjustments applied to pathway (if applicable) |  |
| Date proforma received by MDM *(filled by KCH)* |  | | |
| Patient Pathway Identifier\* |  | | |