

Central Referral Office
Send Referral by Fax: 204-786-0621
Inquiry? Call: 1-844-320-4545

Liver Oncology Referral Guide

(Hepatocellular carcinoma (HCC), Cholangiocarcinoma, Liver mets that are requesting Liver SBRT)

NOTE: This checklist is provided as a guide and is not intended as clinical guidance.

REQUIRED INFORMATION TO COMPLETE PATIENT TRIAGE

Please send a copy of the original results/reports if available or indicate the date and location if ordered.

Liver DSG Disease	Requirements	Required/Preferred
Hepatocellular carcinoma (HCC)	<input type="checkbox"/> Liver imaging within 3 months: CT or MRI scan	Required
	<input type="checkbox"/> Serum bilirubin, albumin and INR. Platelet count within 3 months	Required
	<input type="checkbox"/> Chest CT Scan within 6 months	Preferred
	<input type="checkbox"/> Pathology report (with or without confirmed cancer)	Preferred
	<input type="checkbox"/> AFP within last 3 months	Preferred
	<input type="checkbox"/> Viral Serology (HEP B C) within 6 months	Preferred
Cholangiocarcinoma (including Klatskin's Tumor)	<input type="checkbox"/> Pathology/Cytology report with within last 3 months	Required
	<input type="checkbox"/> CT -CAP Scan within last 3 months	Required
	<input type="checkbox"/> Serum albumin, bilirubin, INR within the last month	Required
	<input type="checkbox"/> CA 19-9 within the last month	Required
	<input type="checkbox"/> MRI Scan within the last 3 months	Preferred
Liver mets that are requesting Liver SBRT	<input type="checkbox"/> CT -CAP Scan within last 3 months	Required
	<input type="checkbox"/> LFTs and INR within last month	Required
	<input type="checkbox"/> MRI liver	Preferred
	<input type="checkbox"/> Liver biopsy and bone scan within the last 12 months	Preferred
	<input type="checkbox"/> Pathology/Cytology report with within last 3 months	Preferred

Liver DSG Disease	Requirements	Required/Preferred
Liver mass/mets with no previous malignancy and/or clinical information suggesting primary DSG	<input type="checkbox"/> MRI Scan within the last 3 months	Required
	<input type="checkbox"/> LFTs and INR within last month	Required
	<input type="checkbox"/> Bone scan within the last 12 months	Required
	<input type="checkbox"/> Liver biopsy within the last 3 months	Preferred

ADDITIONAL INFORMATION

Please send a copy of the original results/reports if available or indicate the date and location if ordered.

Pathology & Operative Reports	<input type="checkbox"/> FNA biopsy - cytology <input type="checkbox"/> Core biopsy
Blood work	<input type="checkbox"/> CBC <input type="checkbox"/> CEA <input type="checkbox"/> Biochemistry, LFTs <input type="checkbox"/> Alphafetoprotein (for Hepatocellular Cancer)
Diagnostic Imaging	<input type="checkbox"/> Abdominal X-Ray <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> Barium Enema <input type="checkbox"/> ES&D <input type="checkbox"/> ERCP (for Hepatobiliary Cancer and Pancreatic Cancers) <input type="checkbox"/> Cholangiogram <input type="checkbox"/> Ultrasound
Other information	<input type="checkbox"/> Hospital discharge summary, if applicable

Additional support for clinicians is available at the Cancer Question Helpline for Health Care Professionals:
Call/Text: 204-226-2262 Email: cancerquestion@cancercare.mb.ca Web: cancercare.mb.ca/cancerquestion