**Suspected Lower GI Cancer Referral Form**

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| **Patient Details** |
| Surname:  | Date of Birth:  |
| Forename(s):  | Gender:  |
| Address (inc postcode): | NHS Number:  |
| Hospital Number:        |
| Telephone Numbers **Please check tel no's with patient** | Tel No (Home): | Tel No (work): | Tel No (Mobile): |
| **GP Details** |
| Referring GP:  | GP Tel No:  |
| Practice Name:  | Practice Email Address:  |
| Practice Address:  | Date of decision to refer:  |

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| **Patient Information** |
| Does your patient have a learning disability?  | [ ]  Yes[ ] No  |
| Is your patient able to give informed consent?  | [ ]  Yes[ ] No  |
| Is your patient fit for day case investigation?  | [ ]  Yes[ ] No  |
| If a translator is required, please specify language:       |
| **IMPORTANT INFORMATION FOR CONSULTANT TO ENABLE TRIAGE STRAIGHT TO TEST:**It is very helpful to have **Hb, HbA1c, U&E’s** and a **stool sample for MCS** checked within last 6 weeks. If the patient has iron-deficiency anaemia a **ferritin level** would also be useful. If the patient has diarrhoea testing should ideally include **B12, folate, TFTs, TTG, LFTs, calcium and plasma viscosity** |
| Is patient on any of the following medications? |
| Aspirin  | [ ]  Yes[ ] No  | Indication for therapy: |
| Clopidogrel /Prasugrel etc .  | [ ]  Yes [ ]  No  | Indication for therapy: |
| Warfarin  | [ ]  Yes [ ] No  | Indication for therapy:  |
| NOAC (Rivaroxaban etc.)  | [ ]  Yes [ ] No  | Indication for therapy: |
| Insulin | [ ]  Yes [ ]  No  | Type 1 [ ]  Type 2 [ ]   |

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| It would be helpful if you could provide performance status information (please tick as appropriate)[ ]  Fully active [ ]  Able to carry out light work [ ]  Up & about 50% of waking time [ ]  Limited to self-care, confined to bed/chair 50%[ ]  No self-care, confined to bed/chair 100% |

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| Please confirm that the patient is aware that this is a suspected cancer referral: [ ]  Yes [ ]  No |
| Date(s) that patient is unable to attend within the next two weeks:      |

***The above details are required before we can begin booking appointments***

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| **Reason for Referral** |
| **Reasons for referring** *Please detail patient and relevant family history, examination ideally including pr, and investigation findings, your conclusions and what needs excluding or attach referral letter.*  |

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| **Referral Criteria** |
| **Colorectal cancer**[ ]  **Consider referring any adult with a rectal or abdominal (but not pelvic) mass that you suspect could be cancer (No age range in NICE guidance)*****Aged*** ***under 50*** with rectal bleeding and any of the following unexplained symptoms or findings (consider):[ ]  abdominal pain;[ ]  change in bowel habit;[ ]  weight loss;[ ]  iron-deficiency anaemia (Hb and ferritin within the past four weeks would be extremely helpful)[ ]  ***Aged 40 and over*** with unexplained weight loss and abdominal pain[ ]  ***Aged 50 and over*** with unexplained rectal bleeding ***Aged 60 and over*** with either of:[ ]  iron-deficiency anaemia ***or***[ ]  changes in bowel habit |
| [ ]  Patient has a **POSITIVE qFIT TEST** – numeric qFIT Value is: |
| **Anal cancer**[ ]  unexplained anal mass or unexplained anal ulceration (consider) |
| **Additional Information** The Lower GI Cancer Team would like to stress that you have referred this patient on the 2ww pathway for cancer exclusion, therefore * We would kindly ask that the referral form is fully completed. Incomplete forms may result in it not being possible to triage your patient and this may lead to a delay in their treatment.
* If cancer is not detected and no further action is required, the patient will be discharged back to your care with advice if needed.
* Any urgent findings will be acted upon by the consultant team.
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| **Clinical Summary** |
| **Clinical History (significant past and current medical history):**       |
| **Current medication:**       |
| **Blood Tests (if available – last 3 months):**      |
| **Allergies:**       |
| **Smoking:**       |
| **BMI** (if available):       |
| **Alcohol** (if available)**:**       |

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| Please send this Suspected Lower GI Cancer referral to the appropriate Provider for your area using their preferred method |
| **2ww Provider** | **Please Use** | **Select Service/email address** |
| University Hospitals Plymouth NHSFT | NHS e-Referral  | DRSS-Western-2WW Lower GI -NEW Devon CCG-99P |
| Torbay & South Devon NHSFT  | NHS e-Referral  | 2WW Colorectal Clinical Assessment-TSDFT-RA9   |
| Royal Devon & Exeter NHSFT | NHS e-Referral | [Two Week Wait Colorectal Surgery / Lower GI- RAS-RDE-](https://nww.ebs.ncrs.nhs.uk/main) |
| Northern Devon Healthcare NHST | NHS e-Referral | [2WW Colorectal Surgery/Lower GI - NDHCT - NDDH - RBZ](https://nww.ebs.ncrs.nhs.uk/main) |

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| **For hospital to complete** UBRN: Received Date:  |