**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? | | | YesNo |
| Is your patient able to give informed consent? | | | YesNo |
| Is your patient fit for day case investigation? | | | YesNo |
| 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 | YesNo | 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: |