

**Suspected Gynaecological Cancer Referral Form**

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| **Patient Details** | | | |
| Surname: | | Date of Birth: | |
| Forename(s): | | Gender: | |
| Address (inc postcode): | | NHS 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: | | | |
| 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 |  | |

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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:  *If patient is not available for the next 2 weeks, and aware of nature of referral, consider seeing patient again to reassess symptoms and refer when able and willing to accept an appointment.* |
| ***The above details are required before we can begin booking appointments*** |

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| **Level of Cancer Concern** (completion optional) |
| **All patients should meet NICE guidelines for suspected cancer 2015**  *“I’m very concerned that my patient has cancer”*  *“I’m unsure, it might well be cancer but there are other equally plausible explanations.”*  *“I don’t think it likely that my patient has cancer but they meet the guidelines.”*  If your patient does not fit the 2ww referral criteria but you still have significant concerns, you may wish to use the Seeking Advice in the ICO service as an alternative to a routine referral.  **Reasons for referring**  *Please detail patient and relevant family history, examination and investigation findings, your conclusions and what needs excluding or attach referral letter.* |

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| **Referral Criteria** |
| **Ovarian cancer – Please ensure a recent CA125 and FBC result is available (less than 8 weeks old) has been requested**  physical examination identifies ascites and/or a pelvic or abdominal mass (which is not obviously uterine fibroids).  ultrasound suggests ovarian cancer |
| **Endometrial cancer (patients will be booked to PMB clinic with USS at appointment if not already done)**  aged 55 and over with post-menopausal bleeding (unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause).  aged under 55 with post-menopausal bleeding (consider). |
| **Cervical cancer (patients will be booked to Colposcopy clinic)**  appearance of their cervix on examination is consistent with cervical cancer (consider). |
| **Vulval cancer**  unexplained vulval lump, ulceration or bleeding (consider). |
| **Vaginal cancer**  unexplained palpable mass in or at the entrance to the vagina (consider). |
| **Advice for Non 2ww**  For patients with post coital bleeding please examine cervix and check smear history is up to date. Email via Advice and Guidance service if required  For patients with inter-menstrual bleeding please examine cervix and check smear history is up to date. Email via Advice and Guidance service if required |

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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)**:** |

**Attachments:** Letter  Medication List  Other

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

In the event of e-Referral service not available - please email to [sdhct.gynaesecretaries@nhs.net](mailto:sdhct.gynaesecretaries@nhs.net) with title “2ww urgent referral”