**Suspected Gynaecological Cancer Referral Form**

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

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| **Patient Information** | | | |
| Does your patient have a learning disability? | | | YesNo |
| Is your patient able to give informed consent? | | | Yes No |
| 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 | 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 |  | |

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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.* |
| **Reasons for Referral** |
| **All patients should meet NICE guidelines for suspected cancer 2015**  **Please detail your reasons for referring, presenting symptoms and your examination findings OR attach a referral letter containing these details.** |
| **Referral Criteria** | |
| ***A recent full blood count would be very helpful.***  **Please see the local guidelines on the Devon Formulary website if you are unsure whether your patient requires referral.**  **Postcoital bleeding and intermenstrual bleeding with a normal examination should be managed initially using local CRG [**[Northern](https://northeast.devonformularyguidance.nhs.uk/referral-guidance/northern-locality/gynaecology/), [Eastern](https://northeast.devonformularyguidance.nhs.uk/referral-guidance/eastern-locality/gynaecology/), [Western](https://southwest.devonformularyguidance.nhs.uk/referral-guidance/western-locality/obstetrics-and-gynaecology), [Southern](https://southwest.devonformularyguidance.nhs.uk/referral-guidance/south-devon-torbay/obstetrics-gynaecology)**]** | |
| **Ovarian cancer -** *please include the ca125 result in your referral.*  Physical examination identifies ascites and/or a pelvic or abdominal mass (which is not obviously uterine fibroids).  Ultrasound suggests ovarian cancer.  **It can be difficult to be certain of clinical pelvic examination findings. If you have a low suspicion for cancer**, **please consider organising 2WW ultrasound where it is available.** | |
| **Endometrial cancer**  Do refer patients aged 55 and over with post-menopausal bleeding (unexplained vaginal bleeding more than 12 months after menstruation has stopped because of the menopause).  Consider referring patients aged under 55 with post-menopausal bleeding.  If a patient is taking HRT ceasing it for six weeks to evaluate bleeding may be helpful when considering referral. | |
| **Cervical cancer**  Appearance of patient’s cervix on examination is consistent with cervical cancer | |
| **Vulval cancer**  Unexplained vulval lump, ulceration or bleeding | |
| **Vaginal cancer**  Unexplained palpable mass in or at the entrance to the vagina | |

**Clinical History (significant past and current medical history):**

<Problems(table)>

**Current medication:**

<Repeat Templates(table)>

**Blood Tests (if available – last 3 months):**

<Pathology & Radiology Reports(table)>

**Allergies:**

<Allergies & Sensitivities(table)>

**Smoking:**

<Diagnoses(table)>

**BMI** (if available):

<Latest BMI>

**Alcohol** (if available)**:**

<Numerics(table)>

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