**Suspected Haematological Cancer Referral Form Adults**

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| **Patient Details** | | | |
| Surname: | | Date of Birth: | |
| Forename(s): | | Gender: | |
| Address (inc postcode): | | NHS Number: | |
| Telephone Numbers  **Please check tel nos 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.* |
| **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.”*  **Reasons for referring**  *Please detail patient and relevant family history, examination and investigation findings, your conclusions and what needs excluding or attach referral letter.* | |
| **Referral Criteria** | |
| **Acute Leukaemia**  *If a blood film suggests an* ***acute*** *leukaemia please arrange an immediate admission with a haematologist.* | |
| **Myeloma**  Results of protein electrophoresis or a Bence-Jones protein urine test suggest myeloma.  Radiology reported as suggestive of myeloma and myeloma screen confirms myeloma  *When considering referral take into account other features including: hypercalcaemia, abnormal full blood count, acute kidney injury.*   * A myeloma screen includes: full blood count, renal function, calcium, protein electrophoresis, urinary Bence Jones Protein * Myeloma is unlikely with a IgG <15g/l or IgA<10g/l in the absence of other symptoms (e.g. renal failure, hypercalcaemia, back pain, bone marrow failure), in which case consider a routine referral * Spinal cord compression or acute kidney injury suspected of being caused by myeloma should be discussed more urgently with on call haematologist * A polyclonal (diffuse) increase in gammaglobulin is not associated with haematological malignancy. | |
| **Hodgkin's & Non-Hodgkin's lymphoma**  Unexplained lymphadenopathy  *Unexplained lymphadenopathy is defined as >1cm and persisting for six weeks*  Unexplained palpable splenomegaly  Unexplained radiological splenomegaly plus symptoms or signs  *When considering referral take into account any associated symptoms, particularly unexplained high fever, drenching night sweats (with or without weight loss), shortness of breath, pruritus or alcohol-induced lymph node pain.* | |

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| **Please attach the following recent pathology results if available (less than 8 weeks old)**  **Myeloma**  FBC, renal function, calcium, serum protein electrophoresis, urinary Bence Jones Protein  **Lymphoma**  FBC U+Es, LFTs, LDH |
| Chronic Lymphoid Leukaemia (CLL) is not an indication for a 2 week wait referral |

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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)**:** |

Contingency email address in the event of e-Referral Service failure. Please put patient’s NHS number in the subject heading.

Plymouth Hospital Trust [plh-tr.RK9Cancer2WW@nhs.net](mailto:plh-tr.RK9Cancer2WW@nhs.net)

RD&E [Rde-tr.opafasttrackteam@nhs.net](mailto:Rde-tr.opafasttrackteam@nhs.net)

NDHCT [ndht.cancerbookings@nhs.net](mailto:ndht.cancerbookings@nhs.net)

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