

**Suspected Haematological Cancer Referral Form Adults**

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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: <Sender Name> | GP Tel No: <Organisation Details> |
| Practice Name: <Organisation Details> | Practice Email Address:       |
| Practice Address: <Organisation 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:        |
| 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.* |
| **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.
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| **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):**

<Summary(table)>

**Current Medication:**

<Medication(table)>

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

<Pathology & Radiology Reports(table)>

**Allergies:**

<Allergies & Sensitivities(table)>

**Smoking**: <Diagnoses>

**BMI** (if available): <Latest BMI>

**Alcohol** (if available) <Numerics>

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